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NEW METHOD OF USING FINGER PAINTINGS

BY WARREN S. WILLE, M. D.

It is well accepted now that art productions give valuable clues to unconscious thoughts. Many different investigators¹⁻⁵ have utilized finger paintings in the study and treatment of mental illnesses. In most of these studies, the subject is allowed to paint at random, without receiving any particular suggestions. A notable exception outside the realm of finger paintings is the work of Harms,⁶ in which children were first asked to portray their concepts of certain words and later asked to draw whatever was passing through their minds.

As an aid in standardizing the use of finger paintings, one of the former staff members of Ypsilanti State Hospital, Dr. Gordon R. Forrer, suggested using stimulus words for each painting, rather than allowing patients to paint at random with no suggestions whatever. During the course of psychiatric interviews, it becomes apparent that patients' conflicts are particularly concerned with certain individuals and situations in the past and present environment. These are used as the source of stimulus words. Thus the stimulus words "mother," "father," "brother," "sister," "wife," and "enemies" may be selected for a given patient. A list of such word stimuli is given by the physician to the occupational therapists, who administer the paintings. The patient is first asked to make a practice painting. A painting is then done in response to each of the stimulus words. The patient is then asked to make a final painting to represent himself. No suggestions other than these key words are given by the occupational therapists supervising the paintings.

If "mother" is the first stimulus word, the patient is told: "This painting is to represent your mother. You may choose a color or group of colors that you would like to use." If the patient is extremely hesitant, he may be told that he might represent "mother" by something that reminds him of her, or tells in some way what she is like. If the patient is still hesitant, the therapist may tell him to choose a color, cover the paper with it, and think of "mother" while working with the paint. No further suggestions are made. The details of administering finger painting work have been described in a recent article in the *American Journal of Occupational Therapy*.⁷ A standardized technique is used, and the

painting is done in a quiet, isolated room where the patient has no chance of being disturbed by questions of other patients, or impressed or influenced by comparison of his own work with that of others. The method of finger painting devised by Ruth Shaw, so well described by Napoli,² is deviated from here in that the administrator does not do a demonstration painting, and no preliminary instructions are given to the patient as to the best technique to follow. It is felt that either of these procedures would alter the results of the test.

To date, approximately 1,400 paintings, done by 200 patients, in the manner described, have been accumulated. These have included productions of both neurotic and psychotic patients of all diagnostic categories. The initial survey of these has given much valuable information, and would indicate that this procedure compares favorably with the Rorschach test in eliciting fantasy material. It is intended to publish in a later article a complete statistical report of the results obtained from this study. Several cases are presented for the sake of illustrating some of the material that can be obtained by using finger paintings in the manner described here.

Figure No. 1. This painting was done by Virginia F. in response to the stimulus word "father." The patient is a 27-year-old single, white female, suffering from chronic schizophrenia, mixed type. This painting, representing the father, reveals a distortion of the usual spatial associations. Father is represented by a shirt and a pair of eyes suspended in space without any enclosing face or other bodily features. Virginia's performance during the finger-painting process correlates with her performance on the Rorschach test, in which she demonstrated considerable blocking and anxiety when confronted with the card representing the dominant male figure.

Figure No. 2. This painting was done by Daisy H. in response to the stimulus to draw something to represent herself. The patient is a 41-year-old married, white female, suffering from schizophrenia, mixed type. In this symbolic painting, she combines the concept of self with concepts of home and children. According to the patient's interpretation, the face at the left represents herself, the other faces representing her children.

Figure No. 3. Bernice C. painted this in response to the stimulus "mother." The patient is a 54-year-old married, white woman,

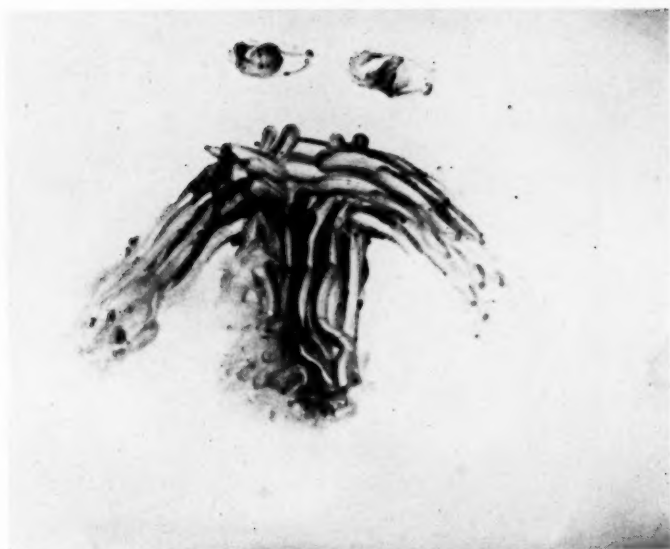


Figure 1

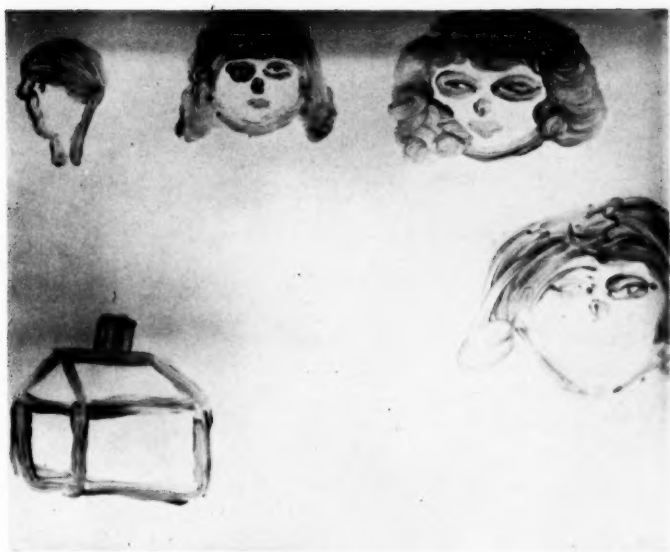


Figure 2



Figure 3



Figure 4



Figure 5



Figure 6



suffering from manic-depressive psychosis, chronic hypomanic phase. The painting representing her mother is done in warm tones of mauve, red and yellow, and demonstrates the typical spatial usage of an expansive manic patient: The figure is large, and the patient goes off the boundaries of the page with the paint. She also adds the name of her mother in bold letters at the side of the page. (The actual size of paper used for paintings is 18 by 22 inches.)

Figure No. 4. This painting was done by Elizabeth C. in response to the word "mother." Elizabeth is a 20-year-old single, white girl suffering from a psychoneurosis with overt homosexuality. She had been rejected by her father and was closer to her mother than to her father. However, she was also resentful toward her mother and ran away from home several times. She began having "crushes" on girls in high school and, later, carried on homosexual relations with one of her girlfriends. The Rorschach record revealed severe sexual conflict, the patient being unable to identify in a healthy manner with either men or women. These conflicts are revealed in her finger paintings. In response to the stimulus word "mother," she portrays mother as a large forbidding, castrating, phallic-like figure standing over a small headless figure (herself). Later in the series, she portrays her father as a small amorphous blob of yellow paint.

Figure No. 5. This was done by Louise C. in response to the stimulus word "mother." Louise is a 27-year-old divorced, white female suffering from schizophrenia, paranoid type. She engaged in homosexual behavior for two years before the onset of her psychosis, which is marked by a good deal of sexual conflict. Her mother is a somewhat aggressive, masculine woman. The patient never knew her father well as her parents were divorced when she was three years old. The stepfather is a kindly, quiet, rather effeminate person. Psychological tests reveal that the patient has a partial masculine identification which is the source of considerable sexual difficulty. In her finger paintings the patient portrays her mother symbolically, with the male symbols, automobile and sun. *Figure No. 6* is also a painting done by Louise in response to the stimulus word "stepfather." She paints a grotesque caricature, with more feminine than masculine qualities. *Figure No. 7* was also done by Louise in response to the stimulus word "girlfriend." She portrays her girlfriend symbolically with

phallic symbols, human figures in suggestive sexual poses, and obscure curlique designs.

Figure No. 8. This was painted by Irene G. in response to the stimulus to make a painting to represent herself. She is a 19-year-old single, white girl, suffering from schizophrenia, hebephrenic type. The painting is chaotic, smeared, and lacks any recognizable forms. Colors are mixed together indiscriminately. Poor form and chaotic arrangement of forms is typical of hebephrenia.

Figure No. 9. Betty R. painted this in response to the word "mother." Betty is an 18-year-old single, white girl, suffering from schizophrenia, mixed type. She is of borderline intelligence, is extremely immature, childish, and insecure. The psychological tests revealed strong passive-dependent needs. These feelings are all revealed in her artistic productions. This scene, showing a small birdhouse in close proximity to a house, is repeated in four of her paintings and represents her wish to be with her mother. The house with a fire on the hearth represents home and mother, and the birdhouse, with face-like markings, represents the patient. The patient also draws a green mushroom-shaped object on the right to represent a tree and a rectangular design at the lower corner to represent a flower bed. Houses, trees, and flowers are frequently used symbolically to represent the mother.

Figure No. 10. This painting was by Kenneth P. in response to the stimulus "mother." The patient is a 27-year-old, divorced, white man, suffering from a severe psychoneurosis, mixed type. He represents the mother symbolically with a moon, a lake, and twin mountains shaped like a pair of breasts. The form and balance in this painting are very good, and are indicative of the patient's relatively good integration.

Figure No. 11. William D. painted this in response to the stimulus word "mother." He is a 22-year-old, married, white man, suffering from a mixed psychosis (manic-depressive, manic phase, with many schizophrenic elements). This painting is a hodgepodge of symbols which include a representation of conception (spermatozoon penetrating an ovum) in the upper right quadrant. The large number of symbols and obscure designs is typical of schizophrenia. Manic elements are also present, as shown by the liberal use of all available colors, the heavy application of paint, and the free use of space, the patient going beyond the confines of the page on all sides except one.



Figure 7

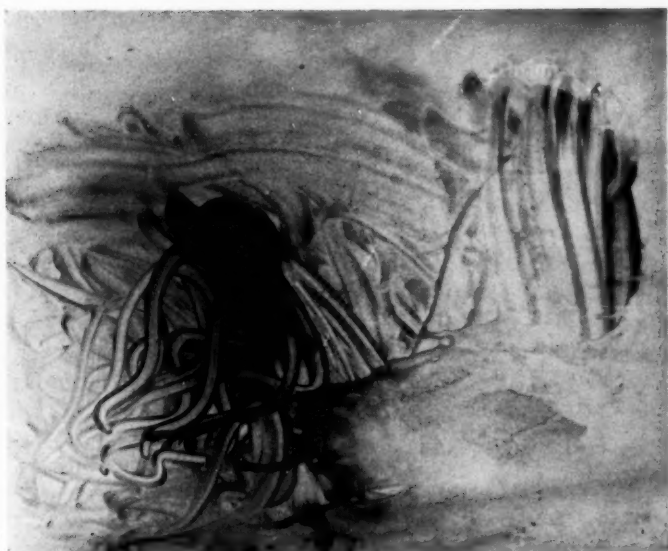


Figure 8



Figure 9

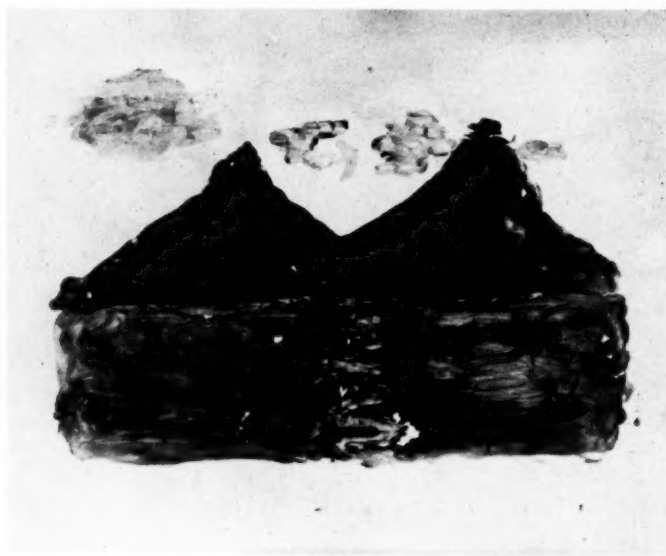


Figure 10



Figure 11



Figure 12



Figure No. 12. This painting was done by Anna K. in response to the word "father." She is a 31-year-old, divorced, white woman, suffering from schizophrenia, mixed type, with paranoid and depressive features. She started out by attempting to draw the face of her father in pencil, then changed to the medium of finger paints and drew the figure illustrated. She said that this represented her father's body (arms and legs), but the design of the male genitalia is rather obvious and reveals the patient's sexual conflicts concerning her father.

A record form devised by the author is used to make note of the data which can be gathered from observation of the painting process and from inspection of the completed paintings. This is based largely on forms previously developed by Napoli,⁸ Alschuler and Hattwick,⁹ and Werner Wolff,¹⁰ with some additions and revisions by the author. While Napoli's finger painting record form was the most suitable of any developed thus far, it was felt that the contributions of Alschuler and Hattwick, and of Werner Wolff, in respect to color and spatial usage, were worthy of incorporation in the record form. The writer has also included in the record form a notation about the patient's affect at the time of the painting process. It is felt that this information would be useful in interpreting the results of each painting session. Copies of this record form and the key used with it may be obtained by addressing a request to the Clinical Director, Ypsilanti State Hospital, Ypsilanti, Mich.

THE RECORD FORM

Page 1 of the record form is very similar to that of Napoli's form and requires little explanation. Space is provided here for comparison of the results of the finger paintings with the results of other psychological tests and with the psychodynamics of the case, insofar as they are known.

The physician studying the completed paintings fills out items A. through T. on pages 2 and 3 of the record form. The occupational therapist administering the paintings fills out items A. through M. on page 3 of the record form (performance observation), and records the patient's verbalizations during the painting process (page 4 of record form).

Pages 2 and 3 of the form are divided into numbered vertical columns for the separate listing of the characteristics of each painting in a series. At the top of page 2 of the record form, a space is provided for marking the word stimulus used for each painting. In the space below this, a notation is made as to whether the painting is a realistic or symbolic portrayal of the stimulus word. For example, if the patient draws a female figure in response to the stimulus word "mother," the painting is designated as a realistic portrayal. If the patient draws flowers, a house, or some abstract design, the painting is designated as a symbolic portrayal of the word stimulus. In case the latter method of portrayal is used, a check is made in the space opposite the appropriate headings of the form (Section B., symbolism, page 2 of record form). The most common symbols encountered are listed on the form, but space is provided for the listing of any other symbols. In the event that the patient chooses to draw human figures in response to stimulus words dealing with people, space is provided for the marking of the characteristics of such figures (Section C., emphasis or omission of parts, page 2 of record form).

Most of the remaining items on the record form are explained in the key used with the form. In regard to the character of strokes used, most of the terms on the form are self-explanatory. This writer follows the definitions used by Napoli² for the terms stippling, tapping, scratching, and smearing (Section Q., character of strokes, page 3 of record form). Spotting refers to localized depositions of paint having the general appearance of ink stains on a blotter. The key devised by Napoli is also followed for most of the items listed under performance observation on page 3 of the record form. An exception is made in the description of rhythm (Section G., rhythm, page 3 of record form). No attempt is made to analyze rhythm in detail. A single notation is made if rhythm is observed in the painting process.

Insofar as is possible, quantitative as well as qualitative comparisons are made in the scale used with the record form. Napoli⁴ assigned numerical values for each subdivision on a 5-point-scale basis where the midpoint is considered average or normal performance. A 3-point scale was used for many of the items on the record form employed at Ypsilanti State Hospital as it was felt that finer differentiations could not be made consistently, either by the same or different observers.

SUMMARY

A new method of using finger paintings is described. Stimulus words are used for each painting, instead of allowing the patients to paint at random. The stimulus words are derived from material uncovered during psychiatric interviews. This method has been found extremely valuable in obtaining fantasy material and compares favorably with the Rorschach test in giving information about the dynamics of the patient's illness.

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Ypsilanti, Mich.

REFERENCES

1. Arlow, J., and Kadis, A.: Finger painting in the psychotherapy of children. *Am. J. Orthopsychiat.*, 16:134-146, January 1946.
2. Napoli, P. J.: Finger Painting and Personality Diagnosis. *Genet. Psychol. Monogr.*, 34:129-231, 1946.
3. Napoli, P. J.: Interpretive aspects of finger painting. *J. Psychol.*, 23:93-132, 1947.
4. Mosse, E. P.: Painting analysis in the treatment of neurosis. *Psychoan. Rev.*, 67:65-82, 1940.
5. Fleming, J.: Observations on the use of finger painting in the treatment of adult patients with personality disorders. *Character and Personality*, 8:302-310, 1940.
6. Harms, E.: Child art as aid in the diagnosis of juvenile neuroses. *Am. J. Orthopsychiat.*, 11:191-209, April 1941.
7. Vogel, R.; Hanke, C.; Miller, H.; and Smith, J.: Finger painting techniques at Ypsilanti State Hospital. *Am. J. Occ. Ther.*, 4:100-101, May-June 1950.
8. Napoli, P. J.: A finger painting record form. *J. Psychol.*, 26:36-43, July 1948.
9. Alschuler, R. H., and Hattwick, LaBerta: *Painting and Personality*. 2 vols. University of Chicago Press. Chicago. 1947.
10. Wolff, Werner: *The Personality of the Preschool Child*. Grune & Stratton. New York. 1946.

CONTRIBUTION OF THE PSYCHOLOGIST TO PROBLEMS OF PSYCHIATRIC DIAGNOSIS AND THERAPY

BY FRED BROWN, Ph.D.

As a member of the clinic team in the psychiatric division of a general hospital, the psychologist's role is to provide as much information as he can concerning the psychological structure and functioning of the patient. He does this by means of projective and non-projective tests which are standardized upon criterion groups diagnosed by psychiatrists who have utilized observations and interpretations in accordance with generally accepted systems of psychiatric classification. This enables the psychologist to make use of an unvarying stimulus situation with constantly varying individuals, and permits him to compare the test performance and total productivity of any particular patient with general group tendencies. Simultaneously he notes the significance of the patient's departures from the most commonly-obtained responses. By correlating the characteristic reaction patterns of various psychiatric conditions with his test findings, he is in a position to offer diagnostic leads and formulations, while a knowledge of dynamic psychiatry allows him to elaborate upon the causative, contributing or precipitating factors in the patient's illness.

In the clinic where therapy is performed only by the psychiatrist and where service functions take priority over research considerations, the psychologist's contribution has dubious significance unless it is constantly oriented toward the therapeutic process. The psychologist might not refer directly to this process, but instead delineate the personality structure in such a way as to enable the therapist to combine the test findings with his own observations and deductions. This focuses attention upon specific areas of the personality and gives them a stereoscopic perspective. More directly, he may make recommendations which emerge logically from the test data.

By providing independent confirmation of the therapist's formulation of the case through so-called "blind diagnosis," that is, by relying solely upon the test findings without any knowledge of the patient's problems or antecedents, the report also adds to the clarity of the psychiatric appraisal and obviates a slower and sometimes unnecessarily cautious approach to the problem. Test results are particularly valuable when the patient's defenses are too

rigid to permit him to verbalize his difficulties, or when persistent negativism results in desultory evasions and banalities which threaten to bog down his treatment. Removed from the conventional give-and-take of the therapeutic or consultative situation and confronted with such unfamiliar material as the Rorschach or the figure drawings, the patient's usual defenses are largely nullified and he frequently and unknowingly reveals significant material about himself which, at the same time, indicates to the therapist whether the defense system should be approached frontally or worn down by slow attrition. Even when a lengthy psychoanalytic treatment is contemplated, such psychological test information at the disposal of the psychiatrist enables him to decide upon a treatment tempo best suited to the makeup of the patient. Several psychiatrists have stated that progress in treatment is sometimes accelerated after a psychological examination, because the patient, feeling that the tests have by-passed his barrier of reserve, is no longer motivated to restrict his verbalizations.

Conspicuous contributions may be made to an understanding of the patient's intellectual functioning quite apart from a knowledge of his mental level in terms of the I. Q. classification. Persistent intellectualizations revealed in the test battery, coupled with a tendency either to theorize or to deal with atomistic and unorganized particulars, suggest that the patient will indulge in broad and affectless generalizations or may magnify trivialities while overlooking or avoiding realistic aspects of his problem. This may foreshadow a protracted treatment, whereas willingness or capacity to deal with practicalities and to express feeling freely can point in the opposite direction. An excessively-concrete attitude, on the other hand, may hinder conceptual thinking and block insight formation. From a practical standpoint, the strength of the patient's ego represents a major determinant in therapy. If the test findings suggest that the ego is brittle and vulnerable to disorganization, or that superficial conformity-patterning disguises its intrinsic weakness, or that a pseudo-competent façade masks the beginnings of its disintegration, then the therapist is forewarned against using a permissive free-association technique for which the patient may have no tolerance and he may therefore employ a slower ego-bolstering approach in order to avoid the risk of precipitating a psychological catastrophe. The test battery, by reason of its high sensitivity to deviant trends in the personality,

often points to psychic "soft" spots long before they become evident clinically.

It is sometimes difficult for the therapist to ascertain whether the patient is limited in his output or repressed. In this respect, the psychologist can offer evidence which will indicate whether the patient has latent resources which can be brought into the function areas of the personality, or whether one is dealing with an essentially impoverished person whose inner resources are meager. This is especially important when one is confronted with an individual who may represent an early simple schizophrenia, borderline mental deficiency, some types of character disorder, or excessive psychic constriction. What sometimes passes for a very inflexible and rigid personality may be revealed as an emotional and intellectually limited one for whom the therapeutic goal must be highly conservative. Or conversely, the tests may bring out surprising potentialities for creative achievements, potentialities which have been gutted by crippling anxieties, masochistic self-destructive needs, or guilt-ridden avoidance of competition with authority figures.

The patient's ego-hampering defenses must ultimately be penetrated and modified by the therapist. Undoubtedly the treatment process itself highlights these defense mechanisms; but in the testing situation they often appear in sharp outline, manifesting themselves as evasiveness, retreat, increased constriction, withdrawal of affect or its restriction, intellectualization of anxiety, blocking, facetiousness, indecision, perseveration on a single theme, fantasy suppression, or outright refusal to make commitments. One sees more clearly the areas in which defenses are mobilized, their strengths and successes, the reasons for their emergence, and the ease or difficulty with which they are overcome. By knowing well in advance the species of defense and the areas in which they are evoked, the therapist not only recognizes them more quickly, but becomes cognizant of their course and ultimate destiny.

The oftentimes vexing problem of affective evaluation lends itself especially well to the probing functions of the test battery. The differential appraisal of affective blunting, inappropriateness, and inhibition creates problems for the therapist, even though fuller acquaintance with the patient may resolve this difficulty. It is helpful however to know at the earliest possible moment whether

one is dealing with the characteristic emotional blandness of certain character disturbances, or marked emotional shyness, or the tight affective structure of the schizoid individual, or the burnt-out affectivity of the chronic ambulatory schizophrenic. In the test situation, one may make valid deductions from the Rorschach and from such graphic techniques as the figure drawings (Buck's House-Tree-Person test) and the Bender Gestalt concerning the amount of available emotional energy, whether actual withdrawal or egocentric preoccupations are operating, whether rapport is easily established or whether it is impeded by an over-cautious and apprehensive "burnt child" diffidence, whether it is forced, superficial, or over-determined, whether it is regressed to infantile narcissistic levels, or whether it is shallow.

The patient who complains of persistent feelings of depression may actually be experiencing a withdrawal of feeling-identification from external objects which is felt as depression subjectively while actually appearing in the tests as a more malignant process. What may seem clinically like blunted affect may be revealed as affective inhibition with fantasy predominance, or labile displays may turn out to be a reaction formation to a deep depressive inclination. The kaleidoscopic variability of affective response to the test battery is seen in such broad variations as the range from gross emotional pathology in the Rorschach color responses (slime, vomit, gangrene), in several levels of strained, and inappropriate affects (green cows), through overtly projected affective attitudes toward drawings (the house is described as bleak, cold, empty, about to collapse; the tree drawing is dead, eaten by worms, covered with ice; the human figure is devoid of feeling, "nowhere, only on paper," surrounded by snow, etc.) to milder forms of dysphoria and sporadic pessimism. By highlighting the complexity of emotional living and clarifying it in any particular case the psychologist throws light upon the patient's transference potentialities and may give meaning to a perplexing clinical picture which then enables the therapist to plan his treatment with greater assurance.

One of the more common obstacles to an objective formulation of the patient's problem for the therapist lies in the counter-transference relationship which is, for the most part, uniquely avoided by the psychodiagnostic test approach. In testing a patient, the psychologist is establishing rapport rather than transference, with just enough rapport to insure maintenance of reactivity to the test

material. It is not only theoretically, but actually, possible for psychologists of comparable competence to evaluate the personality of a patient by painstaking analysis of test findings without ever having seen the patient himself—a fact which attests to the relative freedom of the test data from transference involvements. By means of this approach there is also a decreased probability of content contamination which may sometimes arise out of the therapist's conscious or unconscious directing of the patient's productions toward a predetermined goal, a factor which reduces the confusing role of suggestibility.

The therapist's knowledge of the patient is of necessity obtained through an accumulative process, even though it may be oriented by a generalized formulation of the problems, which remains subject to constant modification as new material appears. The psychiatrist engages in a continual reconnoitering of the patient's psychic terrain until it assumes a familiar and meaningful cohesiveness. In contrast to this approach the organized psychological report should provide a highlighted or pin-pointed picture in which there should be a conspicuous emphasis upon the relationship between adjacent and remote components of the personality structure. In other words, the test report should and can offer a holistic interpretation. This point has significant implications, for the therapist generally relies upon an experimental background (that of his own and others), whereas the psychological report, based upon standardized tests, provides him with a unified pattern—obtained completely apart from the case history material and the patient's subjective description of his problem. The test picture represents an individualized and unique portrayal of a specific patient who has responded to a wide array of projective and nonprojective techniques which can be re-administered as occasion demands, with little change from one administration to another except for such changes as can be attributed to the effects of treatment or other demonstrable interventions. Integration of the test findings and clinical data rounds out a flesh-and-blood depiction of the patient, especially if the therapist constantly co-ordinates the two sources of information.

The test *battery* has been emphasized in opposition to merely a Rorschach study for definite reasons. The Rorschach may provide a comprehensive psychological portrait, but on the other hand it may leave the therapist with little more than vague generalities,

tenuous speculations, or with a description of surface defenses which are readily apparent clinically. Often he is baffled by what appears to be unsupported declarations which stand, so to speak, *in vacuo*. The test battery provides safeguards against irresponsible over-extensions based upon a single instrument, since a well-constructed combination of techniques may tap levels of the personality ranging from what is most conscious to what is deeply hidden, particularly if the test battery provides stimuli which shade off from most to least familiar.

Psychiatrists who are unfamiliar with tests and their rationale will sometimes find what appear to be disconcerting discrepancies between their own impressions and the test results, even when the tests are interpreted by highly-skilled clinical psychologists. It has been the writer's experience that in such cases the test findings and the clinical picture each present only a portion of a meaningful pattern which can assume maximum truth value when the parts fall into place like elements in a jig-saw puzzle. In other instances the test material may be probing at a dynamically deeper level which will clarify the clinical configuration when one seeks to account for apparent discrepancy. Sometimes the patient may consciously be able to give the therapist a more favorable impression of his personality than is warranted, or may offer a less favorable one for a variety of reasons, but the nature of the test material is such that he may find his defenses completely useless and reveal so much of what is taking place beneath the surface as to give a much different account of himself. It is possible, of course, for an inadequately-trained psychologist to construct a misleading personality analysis or even for a well-trained one to misinterpret his data within the limits of human fallibility. In general however, good training combined with broad experience gained through working with psychiatrists who are psychodynamically oriented should reduce the range of error considerably. Hence, lack of point-to-point correspondence need not lead to a rejection of the test results when the competence of both members of the team is unquestioned. Instead, such differences should call for a detailed review of the entire case in a psychologist-psychiatrist conference.

Through his knowledge of symbolism, as this is projected in the content of the test material by the patient, the psychologist can illuminate the values which are attached to figures and attitudes in the patient's life. The problems of psychosexual level, sexual

identification, conception of life role, ambivalencies, authority figures and attitudes toward them, suppressed cravings, dimensions of aggression, specific anxiety-arousing elements and related factors enable the therapist to compare the patient's verbal complaint with underlying conflicts against which the symptom pattern has been erected. While bearing out Freud's dictum that one must go against the current of the patient's verbalizations for what is most significant, the tests throw light upon the current's direction and offer the therapist additional orientation.

At this point a typical psychological report will best illustrate the manner in which test material is organized and presented. This is a "blind" analysis of test data obtained from a 17-year-old boy whose scholastic proficiency was dropping sharply in a good preparatory school. The analysis was in full agreement with the psychiatrist's independent evaluation and diagnosis. Documentary evidence is supplied throughout, since the psychiatrist for whom the report was prepared was familiar with the test battery. Some psychologists prefer to omit supportive data and give only the results, but this is entirely a matter of personal choice.

CASE REPORT

The Bellevue Intelligence Scale reveals bright normal intelligence (Verbal scale I. Q. 114, Performance scale I. Q. 105, Full scale I. Q. 112), with equivalent subtest I. Q.'s ranging from 98 to 143. The test patterning does not show a character disorder, but there is strong evidence for paranoid projective trends which are implied in the ease and efficiency with which he grasps relationships in conjunction with conclusively deviant thinking. In the comprehension test, for example, he answers the envelope question (What is the thing for you to do if you find an envelope on the street that is sealed, addressed, and has a new stamp on it?) by stating, "Stick it . . . no, it depends . . . that's hard to answer . . . there would be something suspicious about the envelope . . . take it to the police . . . the person who dropped it might want somebody else's fingerprints on it . . . if it's bulky turn it over to the police . . . no . . . the postoffice . . . put it in the mailbox." Here, as in so many parts of the test battery, he struggles between conflicting impulses, shifts rapidly from immediate common sense solutions to those which are dictated by paranoid suspiciousness, wavers between the two in a state of painful indecision, and some-

times succeeds in reaching an accepted solution after hastily considering "trap" possibilities. His ambivalence is quite remarkable, making it so difficult for him to arrive at a decision that he remains suspended between various alternatives in a state of inaction.

One would infer that his work at school suffers acutely because of this and that he functions at either an expansive level, with swollen and compulsive output (the number of Rorschach responses is 72 and could have been 200 if the examiner had not limited the number of responses per card), or remains inactive because of his need to be perfect. His compulsive perfectionism and self-doubting is therefore likely to result in extended periods of procrastination. He is evidently aware of his racing ideation, his feeling of being pregnant with ideas, for he often remarked, "I can see tons of things," "I could go on all night," "I can see millions of things in this." When urged to give simple answers he replied, "I want to give both sides," and even after it was explained to him that the simplest statements were required he was unable to modify his approach. In the Rorschach also, he reveals this same tendency in a complete breakdown of an abstract attitude, indicating collapse of survey and abstracting capacity (only 2 per cent of all his responses take in the entire blot area, whereas 20 to 30 per cent is considered normal), a loss of touch with pragmatic and factual aspects of a problem, and an excessive concern with the most irrelevant and picayune features of a situation (56 per cent minute and rare details: the average should be less than 10 per cent). One may, therefore, say that his view of the world is tightly circumscribed by his own concerns.

He demonstrates a marked negativism in the Rorschach which is also seen in his way of answering questions (Capital of Italy: "It's not Rome, not Milan . . ."). His involvement with trivia, aimed at plugging all possible loopholes and therefore anticipating what he suspects to be snares set by the examiner, is illustrated by his response to the question, what is a thermometer? ("there are all kinds, oral, and 98 degrees is normal, rectal, 100 degrees would be normal for that," etc.). In other words, he is capable of building huge mountains out of miniscule molehills.

This is confirmed in the Rorschach, where a small and rarely selected area is perceived as a gorilla; "great, hulking . . . the shape of the gorilla head . . . a monster, enormous, massive." This tendency to build up a towering case from virtually nothing is a

characteristic feature of the paranoid mentality. He is very critical, watches himself closely, and is often able to recognize the absurdity of his conceptions; but on the other hand his low percentage of accurately seen forms indicates a weak ego which is often oblivious to the manner in which the rest of the world regards phenomena, going his own way in order to see in the blots what is more intimately related to his own distorted thought processes. He is still able to prevent himself from bringing out very peculiar ideation in a gross fashion, since he remains sensitive to social situations and can react to them with more or less relevance.

At the same time, and this is the inner contradiction of the schizophrenic, he sees only four of the most commonly seen figures in the Rorschach (the so-called "popular" responses of which there are altogether 21), denoting his distance from common-sense modes of thought, and he is equally deficient in that degree of mental stereotypy which allows the individual to react to the commonplaces of everyday life. Hence, his conformity is quite superficial and very fragile. He seems to exist in a world of his own in which approach to problems is distorted, communality of the thought pattern is torn apart, reality contact is weak, and thought sequence is erratic and confused. Under these circumstances he would be unable to function effectively in either a school or work situation. It may be assumed that there is as yet no frank break with outer reality, since the Bellevue Intelligence scale pattern is essentially well organized, but his demonstrated impairment of attention and concentration (low scores on digits and arithmetic), impaired judgment (comprehension score much lower than information), and his difficulty in differentiating between essential and non-essential aspects of a situation (low score on picture completion) would point to a growing estrangement from the everyday world. From a diagnostic standpoint there would seem to be some depression in this patient, but his high score on the block designs (equivalent I. Q. 119) and the dilated Rorschach output would contradict such a diagnosis.

His behavior demonstrates oppositional traits and sporadic outbursts of veiled aggression against authority which were revealed in various sections of the test (Asked to draw a person, "I'll draw you"; on drawing the tree, "this is bark, don't let it bother you"; during inquiry on the Rorschach, "I'm really giving you quite a run"; asked to point out where he had seen something in the Ror-

schach which was very vague, "Can't *you* see it?"). His refusal to relinquish the drawings even when urgently requested to do so is another case in point, as it was pointed out to him that four or five minutes would suffice for each figure (average for the patient was over 15 minutes). A crushing dissatisfaction with himself was expressed in his constant belittlement of his productions, pointing to a devastating loss of self-esteem which could lead him to suicide if provocation were to mount.

His basic identification is feminine and there is a spate of material which confirms this. In the figure drawings he drew the female first, dwelling lovingly on the hair as if through this he could project his feminine erotic contact wishes. The male figure drawing however is rigid, effeminized, and has "the expression in his eyes, kind of a steely glint, sort of hate . . . (why?) . . . I guess against people who mistreated him . . . he feels tough, bitter. . ." (Of whom does he remind you?) . . . "nobody I ever saw . . . an enemy of mine." This underscores his paranoid aggressiveness which covers over his gravely frustrated passive orality. He would like to identify himself completely with the mother figure in the sense of becoming an integral part of her, like the infant who has not yet achieved a feeling of differentiation from the mother's body. Being unable to attain this state of non-duality, he feels baffled and thwarted, seeking some object against which he could direct his hostility. At times he resorts to blame-placing as a defense mechanism, while at other times he turns against himself in a masochistic manner which generates further frustration. His expansive output (the omnipotent, "I can do anything") and lapse into inactivity express the pendulum swing from omnipotence to desolation. His frustration enables him to obtain proof of rejection by the parents, with the likelihood that the father is singled out as a safer scapegoat than the mother. He can thus secure evidence which he can show the world, so that there would seem to be no support for any suspicion of a paranoid component from what he would consider to be the observer's point-of-view. His real goal however is too unrealistic for effective rationalization.

He rejects his need for tender and loving affection as a result of his greater need to deny his passivity, identifying himself with outwardly directed tension in the activity area (he likes sports). This is seen in his first response to the Rorschach, in which he offers a purely autistic percept of a tail-gunner who is shooting at a pur-

suer. Percepts of gun holsters and other aggressive symbols suggest a tendency toward uninhibited aggressive manifestations and anti-social behavior which would represent an acting-out of his wish to be masculine or to be so considered. He would like to identify himself with a strong father figure, but there seems to be a need on his part to demean (castrate) the father in order to minimize his own intense castration anxiety. There has never been a resolution of the Oedipal struggle, the evidence indicating that he has remained fixated psychosexually at about the age of five years.

This patient is likely to have an aggressive outburst of major proportions, an outburst which could be turned against the environment or take the form of suicide. On the so-called father card (IV) he sees a very ominous percept, "... big clouds in here ... a storm, tornado ... coming down and it's sucking up the wave a little bit." One can deduce a catastrophic flare-up in conjunction with severe sexual tensions which he is unable to handle. He feels strong emotions, but the Rorschach shows that his efforts at social rapport are forced and attenuated, already exhibiting an out-of-tune quality. What remains is egocentric;; but even here he is unable to maintain a steady awareness of the needs of others, since his responses to the color areas are poorly controlled and he is capable of regressing to the emotionally undifferentiated level of the young infant (pure color response, "melted butter"). This points to the beginnings of affective blunting in which a state of emotional amorphousness can be achieved. Beyond his egregious compulsivity and constriction there are no positive mechanisms of control, so that sudden emotional release can result from his unstable emotional equilibrium. This is coupled with his tendency to act out id impulses spontaneously. Underlying all this is his basic incestuous fixation upon the mother.

The oral theme is pervasive (in his drawing of a house the people are toasting marshmallows; there are five food percepts in the Rorschach; his tree drawing "looks like a lollipop"), hinting at the likelihood of a depressive reaction as the forerunner of a schizophrenic breakdown. The presence of cocktail glasses in the Rorschach and his revealing reaction to *Drink* in the word-association test: "Oh God ... water, I guess," (10.9", inquiry, "an unpleasant thought, alcoholic") suggests very strongly that he could become an addict without too much difficulty, especially in view of his defective super-ego. There appears to be an oral-sadistic reaction-

formation to oral-passive-masochistic traits (*Mouth* . . . "food," "I thought of sass") and vice-versa as the situation demands, but throughout the test we find evidence for massive hostility against the father, while toward the mother there is more tender affection (*Woman* . . . "pretty," 9.0", inquiry, "thought of mother; Mother . . . love, I guess," .4"). When given the word Father he replied, "Gee whiz . . . a whole bunch of words . . . Dad, I guess," (246.", inquiry, "I thought of disobedience, punishment").

The Rorschach content analysis supports what has been described. Taking his responses in sequence we find that he is pre-occupied with his masturbation problem and has the feeling of imminent disaster, which stems from guilt feelings over this act and from his aggressive and hostile attitude toward the punitive father. Sex confusion is markedly present, with conscious feelings of bisexuality alternating with his tendency to lean toward femininity (the human male figures on Card III are seen as "very odd . . . shocked at having seen each other . . . realized each looks like the other," and in the inquiry he describes them as "hermaphrodite, half and half," and upon further questioning he exclaims, "yes! looks more like a female . . ."). There are disgust reactions toward the female genitalia (the vaginal form on Card IV is seen as "fungus"), possibly as a reaction-formation to his incestuous fantasies. Fear of mutilation as punishment for his incest is projected in his emphasis upon "nuts" throughout the Rorschach, in his depiction of dangerous "stingers" around the genital area of Card IV, and in his statement that in the percept of a nutcracker on Card V "the nut would go in the *crotch* and go crack," a significant use of language in view of his previous interpretation of this same area as the legs of a woman. Fear of his genital Oedipal cravings drives him to a regressive orality (the usual vaginal area on Card VII, the so-called maternal card, is seen as "a hamburger or cheeseburger") which is supported throughout the protocol. Sadistic impulses are noted in his arbitrary "pink leopards" which "might be an animal with its fur off" even though it is seen as alive. The previously mentioned oral-addictive trend with sexual undertones is emphasized by a highly original but bizarre percept of a corkscrew on Card X and in the melted butter association which was altered from an original statement that it was milk (the area is bright yellow).

In summary, this is a very sick adolescent whose problems are more than adolescent exacerbations. He shows a morbid weakening of the ego with the possibility of a frank schizophrenic break with reality. There is the danger of suicide, a conscious fear of psychosis (in the comprehension test he stated that taxes are necessary in order to build insane asylums . . . is someone in the family psychotic?)*, bitter hatred against the father, incestuous inclinations toward the mother, masturbation guilt with castration anxiety, oral-regressive manifestations, addictive trends, which would serve as ego-destructive substitutes for suicide while at the same time they would punish the father, and paranoid projective symptoms. The need for close surveillance would seem to be imperative in view of the progressive nature of this boy's illness.

* * *

Finally, the psychologist is in a position to make valuable contributions to an understanding of the therapeutic course, and through successive studies of the same patient, to the understanding of treatment sequences in various psychiatric syndromes. By accumulating a mass of quantitative and qualitative material which represents the *status quo* of the patient at the beginning of treatment, he can, by comparing subsequent test findings, trace the course of the symptom and detect changes in functioning which may not be as evident macroscopically as in the delicate shifting of forces often uncovered in a detailed analysis of a test series. Because it focuses attention upon alterations in the intellectual, emotional and imaginal spheres, the therapist may use the psychological report as a basis for steering a new therapeutic course, or he may continue with confidence upon the one he has charted for the patient. In two unpublished studies of treatment sequences over a period of several years, the author has found an impressive agreement between clinical and test findings, which demonstrates that the tests are capable of reflecting changes as they occur and may serve a useful purpose in providing objective confirmation of the therapist's impressions.

This does not mean that the psychologist takes unto himself the complete task of guiding the therapist. His own limitations and the shortcomings of his techniques compel him to maintain a criti-

*The psychiatrist states that a sibling has been institutionalized for several years because of psychosis.

cal attitude at all times. The psychologist operates as a member of a team, contributing to an understanding of the patient on the one hand and learning from the therapist, on the other, the deeper and richer meanings of his own techniques. It is through the insights and human experiences of the therapist, coupled with the experimental methodology of the psychologist, that psychodiagnostic testing acquires value in terms of the patient's welfare, and from this, a broader appreciation of the infinite complexity of human personality.

SUMMARY

In this paper the functions of the clinical psychologist as psychodiagnostician have been delineated. By utilizing both structured and unstructured tests which have been validated against accepted psychiatric nosologies and psychodynamics, the psychologist is in a position to contribute valuable information concerning various aspects of the patient's psychological functioning. These tests enable him to cut through the many obstacles which confront the psychiatrist in his more involved relationship with the patient, but the ultimate value of such test findings is greatly enhanced when they are integrated with the observations and interpretations of the psychiatrist.

The problem of discrepancies between psychological test results and clinical appraisals has been discussed, and a case presentation is offered as an illustration of the manner in which psychological data may be organized.

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SOME OBSERVATIONS MADE DURING GROUP THERAPY

BY CORNELIUS BEUKENKAMP, JR., M. D.

These observations were made at Rockland State Hospital, Orangeburg, N. Y., and are based upon 200 sessions of one and one-half hours in duration. The subjects were male schizophrenics, including pseudoneurotic schizophrenics. The mean average age was 21. Approximately one-third were first admissions and the others all had relatively short institutional histories.

The size of the group averaged 10; it never went above 12 or below 8; a total of 20 patients was treated.

The screening process carried out eventually led to the following criteria:

The subjects were of normal or better than normal intelligence as based upon the Wechsler-Bellevue test. All patients entered into the treatment situation voluntarily after having been seen in an average of about 10 individual sessions. Patients with organic psychoses and physical stigmata were not used, as experience showed that relating themselves to the group and developing transferences was too difficult or impossible. For these same reasons, it was found that the psychopathic personalities also could not fit into this group of young schizophrenics.

During the individual sessions two main functions were carried out. They were felt to be a necessary pre-requisite for group therapy. The first consisted in the voluntary acceptance of the treatment by the individual, with a careful explanation which primarily served not only to inform the patient, but also served the therapist as an opportunity to measure the potential treatability of the patient. Second, it gave the patient an opportunity to free himself of the reality obstacles which—as shown in the term coined by the patients, “hospitalitis”—stood in the way of free participation in psychotherapy. The writer feels that any institutional psychotherapy which does not take cognizance of this “hospitalitis” in the beginning of the treatment will only be plagued by its constant recurrence; and he, therefore, feels it should be dealt with openly in the beginning so that it does not later contaminate the paranoid projections in the treatment setting.

The actual physical planning and operation were carried out in the form of a treatment unit. That is, these group psychotherapy patients all slept in the same dormitory, ate together and had their

own occupational therapy unit. They were well enough to have freedom of the hospital's grounds and, further, had occasional home visits throughout their treatment program. The importance of this collective and closely-knit cohesive enterprise underlined not only the interpersonal relationship during the psychotherapeutic sessions but emphasized, to the patient, the realities of the outside world in which he found himself with his fellow human beings in all phases of human behavior. This, as one might suspect, intensified emotional reactions and their tempo; and frequently the activity-portion of the program reinforced the therapeutic insights gained during the psychotherapeutic phase. The activity of this unit not only served as an excellent inventory for the patient and the therapist but also as an ideal proving ground for the patient's recovery.

Important members attached to the group were: (1) a woman social worker, whose position as a mother figure was assigned to her by the group in the manner often described by Wolf, Slavson, Klapman and others*; (2) a man attendant, who served as an intermediary and liaison between the group and the therapist. The therapeutic value of this latter member was frequently utilized, in bringing under focus material which otherwise would have escaped attention, as in the cases of the more withdrawn members of the group.

The psychodynamics involved were analytically oriented** and used not only the patients' verbalizations but their dreams, drawings and writings. Throughout the entire therapy, concurrent with the group sessions, individual sessions were conducted without any pre-determined pattern or regularity. That is, individual sessions were used at the discretion of the therapist but could be requested at any time by the patient. However, the therapist did not always grant such sessions when asked for, if the problems presented seemed best treated in the group.

*Wolf, Alexander: *The Psychoanalysis of Groups*. American Group Therapy Association Brochure, No. 36. New York City.

Slavson, S. R.: *An Introduction to Group Therapy*. Commonwealth Fund. New York. 1933.

Klapman, J. W.: A didactic approach to group psychotherapy. *Ill. Psychiat. J.*, July 1941.

**Fromm-Reichmann, Frieda: *Principles of Intensive Psychotherapy*. University of Chicago Press. 1950. The orientation used in this paper closely follows the methods advocated by this author.

The first phase of the psychotherapy appeared to deal primarily with the testing of the new therapeutic environment. The therapist was the chief target of this testing process. The testing was done through many ingenious devices in which the reality aspects served as excellent rationalizations. Specifically, the group was concerned with the problem as to whether the new procedure was really for their benefit or whether they were merely guinea pigs in a questionable undertaking. Further, attempts to test the permissiveness of the group were seen through individual rivalry for attention and attempts to elicit hostility from the therapist and the group as a whole.

Other manifestations of this were seen in the projections toward the social worker who, because of her sex, was not immediately accepted as an equal. Not until the problem of the "double standard" in our culture was thoroughly worked through, and it had been demonstrated to all concerned that the social worker could keep confidences, was the general distrust of the feminine sex finally resolved. This was well illustrated with two patients, in whose family structures equal psychological representation of the two sexes did not exist. As these patients worked through this problem, it became rather evident that two processes were under way. Not only testing of the security of the new environment, as already mentioned, but, of greater therapeutic significance, a new formulation occurred. This second process and formulation formed the framework of the treatment setting. That is, when the immaturities surrounding the non-acceptance of women were understood by the group, this new growth led to the realization that the group was a family-like structure. For, when the feminine sex was finally understood to be an equal to the male, this catalyzed the acceptance of the other members of the group, with sibling connotations. It was because of this last realization, after the testing process was complete, that the therapy could progress. That is to say, the material both present and past that was evoked from the sessions eventually related back to this fundamental concept of the family. Thus, the family constellation formed, in the therapist's mind, the second phase of the psychotherapeutic process.

This second phase, which is identified with re-living the process of the family constellation, seems to be the special quality which group therapy affords; and this blends itself into the over-all psychotherapeutic armamentarium. For it is the opinion of the writer

that group therapy is not a substitute for individual therapy or any other therapeutic process known to psychiatry, but is, instead, an important adjuvant. Its use, concurrently with individual treatment, gives, perhaps, a broader basis of treatment and, therefore, potentially a greater reintegration of the total personality structure.

Some of the more specific dynamics encountered were the increased ability of the patient to see his own projections and identify them as such, as a result of having seen his fellow-members project. It is this vehicle within the group therapy framework that enables the patient to recognize the phenomena of transference and to recognize its resistance and its irrationality. This is in keeping with one of the formulations of Sullivan,* when he stated, "As soon as a patient has understood one parataxic distortion and accepted it as such, there is a glimmer of hope for a successful outcome of the psychotherapeutic process." Thus, parataxic distortions are recognized more readily in the re-living process. Their visual images and realistic demonstrations afford easier mental assimilation. That is, insight is more readily obtained, especially initial insight, because the ability to learn through visual and concrete demonstrations is more keenly developed in our culture than are other facets of our intelligence. Educators have accepted this aspect of our learning ability for some time now.

It is this initial inertia, encountered while doing individual psychotherapy, that group therapy can, perhaps, more easily resolve—thus overcoming some of the laborious aspects of the treatment regime.

In the writer's group, as soon as this experience had occurred, the rate of recovery took on a new and increased tempo. This was evidenced by such things as the patients' realistic acceptance of their interpersonal difficulties. The new-found security enabled them to deal with their hostilities toward parents and parent surrogates—a step which, further, led to recovery. On the subject of recovery, such standards as less introspective ideational content and decreased overt narcissistic behavior were used as measuring units. The patient's ability to dispense with use of the group as a "crutch," as measured by his use of the therapist as a mediator and referee, was a welcome outgrowth of the procedure.

*Sullivan, H. S.: *Conceptions of Modern Psychiatry*. *Psychiatry*, 3:1-17, 1940.

Perhaps the most unexpected outgrowth which occurred without solicitation, was the formation of an "alumni association" which the discharged patients maintained back in their home city environment. This served as an excellent medium for their follow-up care. Group therapy *too* needs adequate follow-up care. These "alumni" activities, plus re-visits to the hospital and correspondence with the therapist and still-hospitalized group members, undoubtedly aided in the over-all therapeutic effect.

In conclusion, with respect to the dynamic structure of the group, one would say that apparently these patients succeeded when they were able to resolve their parataxic distortions and develop the realization that internalized attitudes, and not environmental traumata, had been the cores of their previous maladjustments. For, as initial insight occurred and the phenomena of projection was understood, this served to let personality growth resume. This gain allowed the group to realize that their previous difficulties were not simply results of environmental traumata but were the results of what they, as individuals, had done with these traumata. Following these realizations, the family constellation then served its therapeutic role by allowing more healthy personalities to emerge.

The statistics on the group at this point reveal that of the 20 members, 10 have gone out of the hospital on convalescent care, and all have remained out for a combined individual average of 11 months. Of the original 10, eight have left the hospital. The two remaining patients need specialized definitive environmental placements before their discharge can materialize. By first-hand information, the writer knows that the discharged patients are functioning at higher levels than they had previously realized. The combined (group and individual) average length of treatment was 100 sessions. The remaining 10 members of the group are in various stages of remission.

The writer does not feel that the recovery rate, as shown in this group psychotherapy project, should be interpreted as indicating a panacea for schizophrenia, but should serve instead as a therapeutic suggestion for others treating such cases.

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THE ATTITUDES OF COLLEGE STUDENTS AND PENITENTIARY INMATES TOWARD DEATH AND A FUTURE LIFE

BY CHALMERS L. STACEY, Ph.D., AND KARL MARKIN, M. A.

PROBLEM

This paper attempts to extend our limited knowledge of the individual's thoughts, attitudes, and behavior reactions toward death, and his beliefs concerning the possibilities and conditions of an existence after death. In particular, the purpose of the study is to test the hypothesis that the general population is homogeneous in respect to its attitudes toward death. In order to do this, it must, first, be assumed that the questionnaire used is a true measure of one's attitude toward death and, second, that the attitudes of college students and penitentiary inmates may be predicated upon this measure. Thus, if there are no differences in attitudes toward death existing in the general population, there will be no significant difference found between the sample groups.

In addition to testing this hypothesis, the purpose of this study is to determine the thoughts, attitudes, and behavior reactions of each of four groups: one of engineering, one of forestry, and one of law students, and a fourth of prisoners—comparing each group result to the reactions of a hypothetical homogeneous population composed of the four-group total.

METHOD

In investigating the attitudes of the groups, an individual, self-explanatory questionnaire was given to each subject. The items comprising the questionnaire used in this study are not the inventions of the authors, but were selected from questionnaires used by Schilder and Wechsler in studying children's attitudes¹ and from Middleton's research on college students.² Since the present questionnaire and samples differ both in content and composition from those of the previous studies, the results cannot be justifiably compared.

Thirty of the items required that the subject check the preferred response; six of the items were answered by writing in the desired response. The number of possible answers to each item varied from two to six, with only one response to an item permissible.

The items comprising the questionnaire were chosen because of their simple, direct, and unambiguous word composition. A few

typical items follow:

Question: "How frequently do you think of your own death?"

_____very rarely

_____occasionally

_____rarely

_____frequently

Question: "Are you inclined to entertain thoughts of being killed in an accident?"

_____yes

_____no

Question: "Did you ever make an attempt to commit suicide?"

_____yes

_____no

Question: "Would you prefer to know about the future life positively, or would you prefer to have it left as a matter of ignorance or belief?"

_____know positively

_____ignorance or belief

The questionnaires were distributed and filled in during class lectures by 131 engineering students, 122 forestry students, and 55 students in the College of Law, all from Syracuse University. Fifty-two questionnaires were returned from Onondaga Penitentiary, where the inmates filled them out in their cells and returned them to the warden. The ages of the subjects are given in the accompanying table.

Age Distribution of Subjects

	Prisoners	Engineers	Foresters	Lawyers	Total group
Number of cases	52	131	122	55	360
Mean chronological age	29.1	23.2	20.5	24.5	23.4
Age range	17-53	18-35	18-34	19-34	17-53

The total sample is composed of 360 individuals, all men. The prisoner group is predominantly composed of habitual minor offenders, selected only on the basis of their willingness to co-operate and, of course, their ability to read and write. No coercion whatsoever was involved.

There were no instructions given to the subjects orally, but it was repeatedly emphasized that they were not to sign their names on the questionnaires. This statement, which also appeared prominently across the top of the questionnaire, should have given a relaxed sense of anonymity.

The number and percentage of each of the four groups answering each preferred response to each question were obtained. Then the difference between each group percentage and the total group for each category, along with the critical ratio of the percentage, were determined. Thus, the responses of each group are compared with the total group of 360 and not one group with another. This is consistent with the null hypothesis tested, which assumes no differences.^{3, 4}

RESULTS AND CONCLUSIONS

Of the 280 differences obtained, 111 were significant at or above the one per cent level (C. R. of 2.58 or above) and 23 were significant at the 5 per cent level (C. R. between 1.96 and 2.58). Thus, 134 of the 280 differences, or 47.86 per cent, are significant at or above the 5 per cent level. This appears to be sufficient evidence to disprove the null hypothesis: if there are no significant differences in the general population in connection with attitudes toward death, then there are no significant differences between the sample groups.

In reference to the individual groups, the prisoners accounted for 49 of the 111 differences significant above the 1 per cent level, while the engineers had 29, the foresters 16, and the lawyers 17. The predominance of differences in the prisoner group is to be expected for two reasons: First, it is to be noted in the table that the mean age of the prisoners is higher and the age range greater than that of the students. Second, the intellectual and social life of the prisoners is, in general, quite different from that of college students. Although the age difference may play some part, the second factor seems to be the more important, since the engineers, whose mean age differs only 2 years from the total group, account for 29 differences, while the foresters differ 2.9 years from the total and account for only 16 of the 111 differences. In addition, the age ranges of the foresters and engineers differ by only one year. Thus, no conclusions concerning the effect of age on attitudes toward death may be drawn from these results, since other experimental conditions have not been held constant to permit this.

Items concerning typically religious matters were answered alike in most cases. It seems that religious dogma may constitute the primary element of similarity among the groups. For example, 42

per cent of the engineers, 43 per cent of the foresters, 34 per cent of the lawyers, and 56 per cent of the prisoners wished to have the question of a future life left as a matter of ignorance or belief instead of positive knowledge. While there is a considerable difference between the prisoners and the students (as a group), the total group is in general agreement on this matter. Age, again, does not seem to be a factor here: the prisoners, oldest of the total group, and the lawyers, next oldest, were the farthest apart. This general similarity in reference to religion is in agreement with that found by Simpson⁵ in his investigation of the attitudes of college students and prisoners toward the Ten Commandments.

The following conclusions are the most outstanding of the consistent significant differences observed (C. R. of 2.58 or above) and apply only to the responses of each of the groups compared with the total group. In parentheses are shown the differences between the percentage of the group in question and the percentage of the total group.

(1) Engineering students, as compared with the total group:

- (a) think of and imagine their own deaths less frequently and vividly (11 per cent).
- (b) attend funeral services less frequently (11 per cent); less frequently wish that somebody would die (10 per cent); and have less desire to live after death (10 per cent).
- (c) are more indifferent to their own fate (10 per cent).
- (d) are less fascinated by newspaper stories of death (7 per cent); think of suicide less frequently (6 per cent); and less frequently think of being buried alive (7 per cent).

(2) Forestry students, as compared with the total group:

- (a) dread less the sight of a corpse (6 per cent); are less depressed from visiting a cemetery (4 per cent); and are less inclined to have a strong fear of death (5 per cent).
- (b) are more fascinated by poems and newspaper stories about death (9 per cent).
- (c) think more of being buried alive (7 per cent).
- (d) wish more strongly to live after death (9 per cent); and believe more frequently that they will do so (8 per cent).

- (3) Law students, as compared to the total group:
- (a) think of their own deaths more frequently (30 per cent); and are more inclined to entertain thoughts of being killed in an accident (13 per cent).
 - (b) more often dream of dying or being dead (10 per cent); but less often wish that they were dead (18 per cent).
 - (c) more often desire to know about the future life positively (9 per cent); and are more inclined to have a strong fear of death (7 per cent).
 - (d) less frequently believe in future existence (8 per cent); but would more often change their present manner of living if they were sure that there was no future life (10 per cent).
- (4) Prisoners, as compared with the total group:
- (a) think of their own deaths more frequently and vividly (13 per cent); and think of specific fatal diseases more frequently (14 per cent).
 - (b) are more concerned about their own deaths (34 per cent); and think of them more often as being painful (10 per cent).
 - (c) are more depressed by funerals (17 per cent); and cemeteries (18 per cent); and death stories (22 per cent); are more inclined to dread the sight of a corpse (20 per cent).
 - (d) feel that they suppress thoughts about death more frequently (12 per cent); think of suicide more frequently (5 per cent); and have attempted suicide more frequently (5 per cent).
 - (e) worry about a future life (13 per cent); and desire to have the question left as a matter of ignorance or belief (13 per cent); and would more often change their manner of living if they knew there was no future life (15 per cent).
 - (f) less often wish that someone else would die (25 per cent).

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REFERENCES

1. Schilder, P., and Wechsler, D.: The attitudes of children toward death. *J. Genet. Psychol.*, 45:406-451, 1934.
2. Middleton, W. C.: Some reactions toward death among college students. *J. Abnor. and Soc. Psychol.*, 31:165-173, 1937.
3. McNemar, A.: *Psychological Statistics*. J. Wiley & Sons. New York. 1949.
4. Yule, G. U.: In *Introduction to the Theory of Statistics*. Lippincott. New York. 1924.
5. Simpson, R. M.: Attitudes toward the Ten Commandments. *J. Soc. Psychol.*, 4: 223-230, 1933.

THE PSYCHOLOGICAL EFFECTS OF PREFRONTAL LEUKOTOMY ON SCHIZOPHRENICS*

BY EARL E. SWARTZLANDER, Ph.D.

INTRODUCTION

As various types of psychosurgery for the relief of mental illness have gained prominence, neurosurgeons, psychiatrists and clinical psychologists have become increasingly concerned about the effects of such operations. The latest and most complete reviews of the literature on psychosurgery have been given by Greenblatt and Myerson¹ and Kolb.² In general, statements recommending the use, or opposing the use, of psychosurgery have been made with little supportive evidence.

PROBLEM

The problem of this study was to determine the psychological effects of prefrontal leukotomy on schizophrenic subjects. This general problem was viewed as three closely related sub-problems: determining the effect of leukotomy on intelligence, on personality and on ward behavior. This study was limited to adult male schizophrenic subjects who were testable before and after "direct-vision" prefrontal leukotomy operations were performed.

PROCEDURE

The Wechsler-Bellevue Intelligence Scale, the Rorschach, the Porteus Mazes, the Bender-Gestalt, the Draw-a-Person, a sentence completion test and the Roe Behavior Scale were used in this investigation. The intent was to study intensively the psychological effects of leukotomy**³ on a small number of schizophrenic patients. Testing was done three weeks pre-operatively and three months postoperatively.

A sentence completion test, considerably shorter than most commonly-used forms, was developed for use in this study after early attempts to administer this type of test to pre-leukotomy subjects

*Sponsored by the Veterans Administration and published with the approval of the chief medical director. The statements and conclusions by the author are a result of his own study and do not necessarily reflect the opinion or policy of the Veterans Administration.

**Scarff (Ref. 3) used the "open" or direct-vision operative technique on all subjects included in this study.

indicated the need for brevity if minimal co-operation was to be obtained. It was administered pre- and postoperatively, using forms designated as I and II, which contained 25 identical items; but, for variety, the order of arrangement of the items in Form II was the reverse of that employed in Form I.

To obtain evaluations of the effects of leukotomy upon overt ward behavior, the Roe Behavior Scale⁴ was employed. This scale is a combination of aspects of the Gardner Behavior Chart⁵ and the psychiatric rating scale of Malamud, Hoagland and Kaufman.⁶ For each item, descriptions of the various levels of behavior are included in the scale. In completing this scale, pre- and postoperatively, the nurse or attendant on the individual subject's ward who was most competent to observe and to rate his behavior was questioned sufficiently to permit the investigator to assign ratings.

An attempt was made to obtain test data on all schizophrenic subjects who were approved for leukotomy during a one-year period by the Northport leukotomy board. Eleven subjects who were non-testable pre-operatively were excluded from this study. All other subjects were included.

SUBJECTS

The 19 subjects used had appeared before and been approved for operations by the hospital leukotomy board.* In addition, permission to perform each operation was received from the hospital consultant in neuropsychiatry** and from the individual subject's nearest relative.

The age range of the subjects was 23 to 54, with a mean of 34.5 years. Fourteen were between the ages of 23 and 38, and five between the ages of 47 and 54, figures which correspond to the World War II and World War I veteran groups. The mean duration of mental illness was 6.5 years (2.0 to 27.0 years). The breakdown of schizophrenic subtypes was: eight hebephrenics, six catatonics and five paranoids. Four subjects had completed high school, two had completed only the sixth grade, and the mean for the entire group was ninth grade. The highest military grade achieved was sergeant. Fourteen had received no promotions above Pfc, or its equivalent. Military maladjustment was markedly evidenced.

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**Howard Potter, M. D., chairman of the dean's committee.

Seventeen subjects were classified occupationally as unskilled laborers prior to their illnesses. Two were classified as insurance and security brokers. Frequent job changes, many periods of unemployment, and general occupational failure were characteristic.

Behaviorally, these were problem patients. Fourteen had histories of assaulting other patients or ward personnel. Two were so agitated as to require frequent sedation, two had made one or more attempts at self-destruction, and one was resistive and markedly negativistic to all personnel. All were locked ward patients requiring maximum supervision to prevent elopement, suicide, assault, destruction of property and other aggressive anti-social behavior.

RESULTS

Leukotomy and Intelligence

Some mean loss after operation was found in all Wechsler-Bellevue sub-tests except Object Assembly where a negligible gain of 0.74 was obtained. Mean losses were: 1.79 on comprehension, 1.47 on arithmetic, 1.31 on picture completion, 0.84 on information, 0.68 on similarities, 0.47 on digit span, 0.26 on picture arrangement, 0.21 on digit symbol, and 0.05 on block design. Mean losses were obtained of 4.74 in total I. Q.; 6.84 in verbal I. Q.; and 2.48 in performance I. Q. In the Porteus Mazes the mean loss in mental age was 1.44 years. Losses found to be significant at the .01 level are those for comprehension and the mazes.* The loss in verbal I. Q. is significant at the .02 level.

Leukotomy and Personality

The Rorschach Data. Statistical treatment of the Rorschach data did not appear to be warranted, although some personality trends were gleaned from the consolidated pre- and postoperative Rorschach protocols.

Comparison of the two consolidated Rorschach protocols yields the following post-operative trends: reduction of mean F+ per cent from 53.2 to 37.3, indicative of loss of respect for reality; re-

*The standard error of the difference between means in terms of the differences between paired scores was obtained by the formula suggested by Peters and Van Voorhis (Ref. 7): $\sigma M_x - \sigma M_y = \sigma d \div \sqrt{N-1}$ in which σM_x and σM_y are the standard errors of the initial and final test means, and $\sigma d \div \sqrt{N-1}$ is the standard error of the difference between means divided by the square root of the number of cases less one.

duction of mean number of content categories from 7.3 to 5.4, interpreted as increased narrowing of intellectual interests; reduction of mean number of popular responses from 3.6 to 2.6, evidencing reduction of conformity level; and increase in mean time for the first response from 23.3 to 28.7 seconds, suggesting some slowing of intellectual processes. No other tendencies toward personality change were reflected in changes in the Rorschach protocols.

Piotrowski⁸ studied 18 organic brain disease cases with the Rorschach, and postulated 10 signs of cerebral lesions. Six of these signs in any record, he regarded as strongly suggestive of organicity. The mean number of these organic signs found in the pre-operative records of these 16 subjects was 3.3, in the postoperative records, 4.0. Clearly, Piotrowski's signs of organic brain damage did not identify these subjects as organics after leukotomy operations.

The Draw-a-Person Data. Two subjects would not co-operate pre-operatively in the Draw-a-Person Test; and, although they produced drawings after operation, their records have been excluded from this part of the study. Each of the individual drawings was rated on a 5-point scale designed to give reasonably objective evaluations of the drawings which would permit comparisons of drawings made before and after operation.

A rating of 5 was assigned to any drawing that included good body proportions (head approximately one-seventh as long as the entire figure; arms and legs well proportioned in relation to the body as a whole; and facial features such as the eyes, ears, nose and mouth proportionate in size to each other and to the head); realistically arranged and clearly differentiated facial features and body parts; and no bizarre features.

A rating of 4 was assigned to any drawing that was in good body proportions with minor deviation; slight deviations in arrangement of differentiation of facial features and body parts; slight evidences of bizarreness (i. e., skirted woman with naked chest); and some acceptably emphasized facial features (i. e., heavily shaded eyes, ears, lips, open mouth, etc.).

A rating of 3 was assigned to any drawing that included fair body proportions; some distortion of features (i. e., small arms, pin-point eyes, etc.) clothing present but inaccurate or insufficient;

and considerable overemphasis on particular features (i. e., busts, trouser fly, etc.).

A rating of 2 was assigned to any drawing that included poor body proportions with crude, poorly-attached or missing body and facial features; mal-proportioned head; crude or absent sex differentiation; clothing absent or sack-like; some conspicuous bizarreness present; with an over-all impression of an immature childlike drawing.

A rating of 1 was assigned to any drawing with extremely deviant body proportions; grossly distorted, fragmentary or missing appendages or facial features; transparent or no clothing; sex differentiation absent; and conspicuous bizarreness present to an extreme degree. Drawings of microscopic size were rated as 1. It was not intended that the scale distances between the various ratings would be equal, but changes from lower to higher numbers do indicate improvement in terms of concept of body image and the self. The converse is indicated by changes in ratings from higher to lower numbers.

After operation, 10 subjects produced better drawings, four produced worse drawings, and three produced drawings that were rated equivalent to their pre-operative drawings. The mean rating of the male-figure drawings rose from 1.94 before operation to 2.35 after operation, a mean difference of $+0.41$. The mean difference would be significant at the 0.10 level and may be regarded as suggestive if not reliably significant. The change in mean rating of female-figure drawings, although also in the direction of improvement—from 1.94 to 2.24, or a mean difference of $+0.30$ —is not significant. The mean additive rating for both male and female figure drawings increased from 3.88 to 4.59, a mean difference of $+0.71$, which also is not significant. In general, the schizophrenic character of these drawings was not significantly changed after leukotomy, and there was no indication in the production of any subject of any activation of creative artistic ability by the operation.

The Bender-Gestalt Data. The pre- and postoperative Bender-Gestalt design reproductions of each subject were analyzed with fine measuring instruments and, where possible, it was determined which of the two reproductions was best; that is, least deviant from the stimulus design.

Of the eight schizophrenic signs postulated by Hutt⁹ for the Bender-Gestalt, the five which were found to be objectively scorable were: rotation, regression, fragmentation, shape distortion and chaotic or confused order. In the 17 pre-operative test records the mean number of signs scored was 13.2 and the range was 4 to 23. In the postoperative records the comparable mean was 9.0 and the range was 4 to 16. Fourteen subjects improved, two became worse and one was unimproved after operation, using decrease or increase in the number of schizophrenic signs on the Bender-Gestalt as the criterion of improvement. This improvement was, in general, evenly distributed for all five signs. The Bender-Gestalt data are suggestive of more accurate perception and improved integrative capacity following leukotomy.

The Sentence Completion Data. An adaptation of the scoring system devised by Rotter and Willerman¹⁰ was used to obtain objective scores on each of the 25 sentence completion test items for each subject, pre- and postoperatively. Each item to which a response was written was scored as: C—conflict or unhealthy, P—positive or health, or N—neutral. Five subjects failed to answer a minimum of 40 per cent of the test items, and their test data were excluded. The responses, pre- and postoperatively, for each of the other 14 subjects were computed on a percentage basis. Thus, a subject who produced 10 conflict, five positive and five neutral responses and who did not respond to five items would have 50 per cent conflict, 25 per cent positive and 25 per cent neutral responses. The pre-operative mean percentages were: conflict 50.6, positive 24.9 and neutral 24.5. The postoperative mean percentages were: conflict 45.5, positive 27.2 and neutral 27.3. These changes are not significant. The attitudes and thought content measured by this test were not demonstrably affected by leukotomy.

Leukotomy and Ward Behavior

The Roe Behavior Scale Data. The ward behavior of all 19 subjects was rated with the Roe Behavior Scale pre- and postoperatively on sleep, appetite, activity, attention to appearance, toilet habits, care of property, work activity, general mood level, co-operation in routine, speech, aggressive behavior, social behavior, and sexual behavior. Each of these items was rated +2, +1, 0, -1 or -2, with 0 representing "normal" ward behavior, +2 extreme deviation in the excessive direction and -2 extreme deviation in

the insufficient direction. Ratings of +1 and -1 represent mild deviation in the direction of excessive and insufficient behavior respectively.

Disregarding the direction of deviation from normal (+/- signs) the pre-operative mean total score for 19 subjects was 10.76. Postoperatively the mean total score was 8.13. Both scores are indicative of considerable deviation from the "normal" pattern of ward behavior. The mean decrease of 2.63 points indicates improvement after operation, and is significant at the .05 level.

The categories of behavior which reflected improvement were: general activity (1.18 to 0.50), aggressive behavior (0.87 to 0.29), work activity (1.63 to 1.21), sleep (0.39 to 0.05), mood level (1.16 to 0.84), co-operation in routine (1.05 to 0.74), social behavior (1.37 to 1.10), appetite (0.39 to 0.21), and speech (0.97 to 0.82). Categories of behavior which reflected loss were: toilet habits (0.08 to 0.37) and attention to appearance (0.53 to 0.92). Slight changes occurred in the scores of care of property (0.87 to 0.79) and sex behavior (0.26 to 0.29). Fourteen subjects made improved scores ranging from 1.5 to 12.0 with a mean of 5.1; and five subjects suffered losses in scores ranging from 2.0 to 6.0 with a mean of 4.4. Most of these losses were concentrated on the insufficiency (-) side of attention to appearance, toilet habits, and social behavior.

In terms of numbers of subjects who secured plus, zero and minus ratings for each of the behavior categories, pre- and post-operatively, there were changes in sleep, appetite, co-operation in routine and social behavior in the form of lessening of underactivity toward normal ward behavior. There was marked reduction toward normal of excessive activity and aggressive behavior. Definite loss in attention to appearance was evidenced by a trend toward unconcern and general carelessness. To a lesser extent, a similar loss occurred in toilet habits. Changes in the other categories were too slight to warrant comment.

DISCUSSION AND CONCLUSIONS

In general, global or total intelligence is not significantly affected by leukotomy, although intellectual damage in specific areas does occur. Verbal intelligence and those functions which require verbal ability appear to be most consistently effected adversely. Significant losses occur in the functions of judgment and planning ability, and social resourcefulness. These losses are reflected in

the comprehension subtest of the Wechsler-Bellevue and in the Porteus Mazes. There is a suspicion that intellectual loss occurs more frequently in subjects above the age of 30 than in the younger subjects, but this will need to be confirmed in a larger group than that used in this study.

Personality from a total view does not appear to be significantly affected by leukotomy, although certain trends are noted. The leukotomized schizophrenic tends to have a more narrow range of interests, tends to be more apathetic and anergic, and tends to be less conforming and more estranged from the world in which he lives than he was before operation. Some schizophrenics seemingly tend to profit from these personality changes. Subjects who before operation were hyperactive, assaultive, and/or suicidal and emotionally tense, did poorly in general on all tests, but particularly so on the Draw-a-Person, Bender-Gestalt and sentence completion tests. After operation, these subjects tended to be somewhat more docile, and accordingly were less un-co-operative than before operation, and this would help to explain the tendencies toward improvement on the rather simple tasks. Such improvement as does occur is in the visual-motor area. Postoperatively, these subjects are less dangerous to themselves and to others than they were before operation, but there does not appear to be any increase in their potentials for independent non-hospital adjustment. As they lose their drive, they tend to acquire somewhat better concepts of the self and, in very simple situations, tend to manifest improved perception and adaptability. As they become less active, they become less obstructive, and this makes it possible for them to be given more nursing and ward care and assistance, which in turn results in what appear to be improved personality attributes. The personality ceilings of schizophrenics may or may not be lowered by leukotomy, but it does seem that their personality floors have been raised.

The most outstanding effect of leukotomy on schizophrenics is the "improvement" of their ward behavior. Improvement, as used here, means increased ward manageability. This is looked upon as improvement by those persons who have the responsibility of taking care of these subjects, but it is best regarded as "changed, though unimproved behavior" from a clinical point of view. The increased interest in these subjects displayed by all ward personnel after operation, together with the conditions previously cited, tend

to result in better habits of sleeping, eating and speaking. A few subjects suffer such loss of bladder and bowel control that even extensive toilet-habit retraining is only moderately effective. Paralleling this loss, is a tendency toward reduction of "regard for personal appearance," which also does not seem to be corrected by intensive training.

The results of this study suggest an immediate need for a much more far-reaching investigation of the psychological effects of leukotomy on all subjects that might come within the scope of this operation. It is concluded that leukotomy, within the limits of this study, is at best of little or no value as a therapeutic device for schizophrenics, and is at worst destructive of important intellectual and personality potentials.

For each leukotomy of the future, the probable effects, desirable and undesirable, on each individual subject should be very carefully estimated and considered before the operation is finally performed. The possibility of spontaneous remission should not be overlooked, even in those subjects who have been mentally ill for long periods. Even with the most carefully selected cases, it appears that spontaneous recovery remains a possibility, however remote that possibility may be.*

It is especially desirable that a frank estimate of the probable effects of leukotomy on each individual subject be given to the relative who is asked to grant permission for operation. Preparation of the family unit for any personality changes that may occur would be best placed in the hands of specially trained social workers. Leukotomy remains an operation of desperation and is of very doubtful therapeutic value even with the most carefully selected subjects. Interested relatives should be told this. It is suggested that the effort now being expended in leukotomy programs might well be better directed toward an intensive search for other less damaging therapeutic programs. Until sufficient understanding of the schizophrenic process itself has been gained, it is not likely that adequate therapeutic programs of this type can be planned and conducted on a scientific level.

*One subject, who had been severely ill mentally for five years and who was so assaultive, suicidal, and at times so mute, that he could not be tested after approval by the leukotomy board, made such a complete and spontaneous recovery while awaiting operation that the leukotomy was not performed. After a suitable waiting period he was placed on trial visit status and for two years has continued to adjust satisfactorily at his home.

SUMMARY

The problem was to determine the psychological effects of prefrontal leukotomy on schizophrenics, with particular attention to the effects on intelligence, on personality, and on behavior. The subjects were 19 male schizophrenic patients who required maximum hospital supervision and who had been seriously ill mentally long enough to warrant a poor prognosis.

All operations were performed by Scarff, using the "direct-vision" operative technique. The test battery used was the Wechsler-Bellevue, the Porteus Maze, the Rorschach, the Draw-a-Person, the Bender-Gestalt, a sentence completion and the Roe Behavior Scale. This battery was administered pre-operatively and post-operatively after three months.

There was a significant loss in verbal I. Q. and in the Wechsler subtest for comprehension, as well as a significant loss on the Porteus Mazes. Judgment and social resourcefulness were significantly adversely affected. The important effects on personality were found to be narrowed intellectual interest, increased apathy and anergy, reduced respect for reality, lower conformity, improved concept of the body image and the self, and improved perception and adaptive behavior in simple situations.

The general effect on ward behavior was found to be improvement. Areas most affected were general activity, work activity, co-operation in ward routine, aggressive behavior, general mood level, social behavior, sleep and appetite. Important losses were found in attention to appearance, and toilet habits. Improvement of behavior in terms of ward manageability was found, although the schizophrenic process itself was not affected.

It is concluded that a more far-reaching study of leukotomy is urgently needed. It is suggested that the probable effects of individual operations be determined and communicated by a trained social worker to the relative who is asked to grant permission to operate. It is further suggested that leukotomy programs be deferred until a more complete understanding of the schizophrenic process has been gained.

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REFERENCES

1. Greenblatt, M., and Myerson, P. G.: Psychosurgery. *N. E. J. Med.*, 240:1006-1017, 1949.
2. Kolb, L. C.: An evaluation of lobotomy and its potentialities for future research in psychiatry and the basic sciences. *J. N. M. D.*, 110:112-148, 1949.
3. Scarff, J. E., and Kalinowsky, L. B.: Prefrontal lobotomy under direct vision. *N. Y. S. J. Med.*, 47:2669-2675, 1947.
4. Roe, Anne: The Roe Behavior Scale (unpublished).
5. Wilson, P. H.: The Gardner Behavior Chart. *Am. J. Psychiat.*, 98:874-880, 1942.
6. Malamud, W.; Hoagland, H.; and Kaufman, F. C.: A new psychiatric rating scale. *Psychosom. Med.*, 8:243-245, 1946.
7. Peters, C. C., and Van Voorhis, W. R.: *Statistical Procedures and Their Mathematical Bases*. P. 165. McGraw-Hill. New York. 1940.
8. Piotrowski, Z.: The Rorschach inkblot method in organic disturbances of the central nervous system. *J. N. M. D.*, 86:525-537, 1937.
9. Hutt, M. L.: A tentative guide for the administration and interpretation of the Bender-Gestalt Test. *U. S. Army T. A. G. School*, 1-11, 1945.
10. Rotter, J. B., and Willerman, B.: The incomplete sentences test as a method of study personality. *J. Cons. Psychol.*, 11:43-48, 1947.

THE ENVIRONMENTAL TREATMENT OF PSYCHOSIS*

BY ALLEN J. ENELOW, M. D.

In recent years there has been an increasing interest in the active use of the facilities of the hospital environment for therapy with psychotic patients. Concepts of case management as therapy seem to fall into two generally definable different trends. The first of these is the "total push" concept, which is based on the theory that patients will maintain more highly organized social behavior if pushed and kept busy; this involves a fairly non-specific choice of activities.¹ The other trend, in a somewhat different direction, is the attempt to individualize the management of cases (including selection of activities) to as great an extent as possible. This concept had its beginnings in small, largely psychoanalytically-oriented hospitals that were well staffed.^{2,3} In this second approach, an attempt is made to carry out a systematic program oriented to the individual needs of the patient in the sense of creating conditions in which the patient can regain emotional balance.

In discussing the latter trend, Adams⁴ states that there is a growing appreciation that even the most regressed patients are influenced for better or worse by the environment; and that the most important part of the environment is the people in it. He described a set of systematic attitudes, which were in use at a private sanatorium for many years, that could be prescribed and communicated to all persons who would have contact with the patient. This is a very highly-refined application of the concept.

If the hospital environment is to be utilized for individually-oriented therapy, the traditional approach to case management must be altered. The therapeutic approach to case management postulates that the hospital exists for the patients, not that the patients exist for the hospital.⁵ The unspecific use of the environment, as in "total push" programs, or in institutions where the attempt is to keep the patient busy at various chores about the hospital, is not predicated on this viewpoint, but rather on an autocratic, impersonal philosophy.⁶ Moreover, some patients are incapable of tolerating much external pressure and tend to get

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lost or to be pushed back to chronic wards where no attention is paid to them. Others may conform, but in a totally mechanical and personally distasteful way, tending to "keep up a front" while they gradually withdraw and psychologically crumble behind it.

Individualizing the use of the environment to a therapeutic end, ideally calls for the understanding of each patient's needs. It particularly means flexibility in the activities in which he may participate and in the way he participates. It does not necessarily mean a wide number of available activities, or highly specialized activities which are expensive to the hospital. It refers rather to the aspect of them that might be chosen, the way they might be used and the attitude of the staff toward the patient. Some patients should be urged to work or participate, others requested to do so, and still others permitted to participate intermittently or not at all.^{7,8}

The most important therapeutic element in the environment is not its manipulation *per se*, but, as mentioned by Adams,⁴ the people in it. Effective environmental therapy is only possible where interpersonal relationships between staff members and patients are possible.

Thus, in one sense, environmental therapy is largely relationship therapy. This relationship therapy, or rational case management, is predicated on the same basis as all psychotherapy. The most important element in psychological therapy is that at least one person make emotional contact with the patient. The more regressed the patient, the more difficult this is. With psychotic patients it requires a consistent, friendly, but not threateningly, warm attitude. More is required than just a "friendly front." In fact, a genuine interest in the patient on the part of the staff member is essential for a therapeutic relationship.

It may be said that emotional contact has been made when the patient responds to the friendship of the therapist. By therapist, is meant any member of the staff who works with patients. It may be a physician, nurse, attendant, or any other individual in this concept of therapy. An interpersonal relationship can then be built by the continued contact between them, and the development of feelings about each other. This can be done in a group situation where the therapist works with a number of patients as well as in the highly specialized situation of individual psychotherapy. Relationship therapy then amounts to the exploitation of this re-

lationship by the therapist, who allies himself with the strengths and the potentials toward recovery which every patient has. Where necessary, he supplies control of impulses and sets reality boundaries for the patient. If the relationship is good, the patient identifies himself with the therapist and takes over his standards and his approach to situations which the patient is ordinarily incapable of meeting effectively. Theoretically, the patient is potentially capable of internalizing, or introjecting, these characteristics of the therapist. The therapist's strength becomes a part of the patient.

In practical application, this process can occur under any circumstances in the hospital and in any activity to which a patient may be assigned and in which he has the opportunity to form a relationship. The activity itself must be exploited so as to capitalize on the strengths and abilities which become manifest in the patient, whether it be creative work, or tedious tasks, or in some instances, merely anything the patient can accomplish.

The great barrier in most hospitals to individualizing case management is the great shortage of trained therapists. In practice, the people who spend the most time with patients have the least training and often work with little or no supervision. Many have no opportunity to learn how they may work more effectively with patients. Others have the attitude that they have work to be done and that the patients are there to help get that work done, or are, in some cases, impediments to its accomplishment.⁶ However, in probably every hospital, there are some untrained and unsupervised individuals who have remarkable successes in working with patients. These are usually those who are intuitively aware of their roles with the patients and who, spontaneously, have genuine interest in their patients. The comparatively few psychiatrists on the staffs of larger hospitals are usually far too busy with administrative duties to be able to devote enough time to direct management of many cases.

It has perhaps been too little recognized that one of the most important administrative duties of a psychiatrist is the supervision of his staff in contacts with the patient. There is probably no hospital in which this supervision cannot be effected. In practice, everyone who works with patients should attend case conferences and should have regular group supervisory sessions with psychiatrists. At these times, the problems of case management, both in

general and as applied to specific patients, can be discussed, and members of the staff may voice and try to work out attitudes relating to the patients with whom they work. The philosophy of good patient-care is communicated only through such means.

The value of the psychologist and the social worker to the patient is just as much enhanced by working directly with the psychiatrist as that of other members of the hospital staff. This is well known, but, what is usually not emphasized is that there is a reciprocal value. All members of the staff are better fitted for working with patients by collaboration with members of other disciplines. An example of this is the problem of the patient's relatives. The psychiatrist traditionally regards relatives as minor (and sometimes major) nuisances. Psychiatrists, particularly those with a psychodynamic background, tend to think of relatives only as the people who caused or contributed to the patient's illness. Yet we expect to send the patient back to his relatives in the majority of instances. It is difficult to think of the psychiatrist, particularly when he identifies himself somewhat with the patient, as being capable of helping the relatives to whom he wishes to send the patient. The social worker, feeling more acutely the problem of the relatives, supplies the balance needed for judicious evaluation and is the best person to empathize with them sufficiently to help.

Here, again, shortages and large patient loads interfere. In general, the psychologist, psychiatrist and social worker work alone, though on the same patient. Much has been spoken and written about the "psychiatric team," but this expression rarely goes beyond the stage of being a good idea. The concept of the psychiatric team comes closer to being realized when the staff is relatively large, but in hospitals where available psychiatrists, psychologists, social workers and nurses must be distributed widely and thinly, it often appears difficult to effect a practical working "team." The only feasible approach is appropriate distribution and organization.

In one hospital, where the author was faced with a problem of staff shortage—though not too severe—appropriate distribution was achieved by the development of so-called "ward teams." The psychiatrist, psychologist and social worker worked as a traveling unit which visited each ward at a regularly scheduled time to hold a conference with the resident physician, nurses and aides on that

ward. While it is true that there was a sufficient quantity of resident physicians at this hospital, a condition that does not generally prevail, it is felt that these meetings are worth studying and that they would be of value with or without resident physicians. Under ideal circumstances, all members of the staff concerned should be present.

The meetings were devoted to the problems of individual patient care, or of general ward administration. Usually one or two cases were presented. After a discussion of the history, the patient was interviewed in an attempt to assess his assets and liabilities more directly. The patient was then discussed, with all present contributing information and making suggestions, either as to further work-up or details of management. An attempt was made to discuss each patient who was being considered for transfer to a ward requiring a more complex social adjustment. In addition, new cases were routinely considered.

Among the effects of this system have been better co-ordination of social work and case management, and better selection of cases for psychological testing. Most important, there has been better understanding of patients by those who spend most time with them. Evaluation of the patient has been improved by the addition of observations from several different standpoints. Thus, staff members with limited time were able to obtain much more complete data on patients than would be possible by attempting direct observation. The opportunity to discuss the recommendations was always taken, so that all participants would more fully comprehend their rationale.

One of the most frequent occurrences arising from these conferences was the "discovery" of a patient who had a therapeutic potential that had gone unrecognized. Many times the problems resolved were minor ones in terms of the over-all clinical problem, but important ones for the patient—such as feeding problems. The following are two examples of problems managed through team meetings.

Case 1—R. J.

The patient is a 28-year-old, white, married man brought to this hospital on April 16, 1949 after his wife reported that he had hallucinations and had threatened her with a gun. The patient is the oldest of four siblings of an overprotective mother and a disinter-

ested father. A behavior problem in childhood, and delinquent during adolescence, he frequently got into difficulties from which his father would invariably rescue him. The father remained distant and uninvolved at other times.

R. J. entered the army in June 1943 as an alternative to imprisonment for a theft. Overseas, he developed seclusiveness, insomnia and, later, acute anxiety with suicidal agitation and delusions of reference. He was discharged and then married. He continued to have difficulty, did not work, passed bad checks, and was supported by his wife. His father continued to rescue him from his difficulties. In April 1949, while in some difficulty with the law, he became angry at his wife on a motor trip. He threatened her with a gun, drove fast and recklessly, stating that he was following directions given him by "voices."

The wife made contact with police, who brought the patient to the hospital by force. In the hospital, the acute episode passed, over, but psychological tests indicated an underlying psychotic process. R. J. alternated between being very passive and very belligerent and would become angry at the slightest frustration of his wishes. He was presented at a team meeting where he asked for a discharge. At this conference it was decided to confront him with his feeling that something was "owing him" and to inform him firmly that he would be committed.

All personnel were to adopt a very firm, but friendly approach to the patient. Insistence on his regular and consistent attendance at shops was to be made. He was encouraged to exploit creative abilities in cabinet work. He began to respond remarkably to this approach, and within a month was seen to be able to tolerate frustrating incidents without outbursts of anger. All personnel rewarded him with commendation for good handling of his anger, but treated him very firmly when he was angry. The patient has since been transferred to an open ward where he is realistically working out his problems in reference to his legal difficulties.

Case 2—L. W.

L. W. is a 31-year-old, white, unmarried man who was admitted to this hospital in February 1949, complaining of fear and loneliness. He was one of a large number of siblings born to a low income farm family. His mother had died when he was four. The patient was considered the stupid member of the family, and was

shunted about constantly from one older member to another after his mother's death. He felt that no one liked him and that he had no home. He managed to get to the sixth grade in school, then left to take up a nomadic life including three years in the CCC. At that time he began to feel that his uncle had been murdered, but no one listened to his idea.

He served as a private in the infantry from 1943 to 1946, and was never hospitalized, in spite of the fact that he had auditory hallucinations telling him that the uncle had been murdered. He was also delusional, feeling that he had hidden treasure. In 1946 he began to have visual hallucinations of his uncle.

L. W. came to the hospital voluntarily "because no one was interested" in him. On admission he was noted to be confused, frightened, and pitifully grateful for any attention. He had visual and auditory hallucinations, and a strong delusional system concerning the death of his uncle. The patient was continually seeking to make friends with other patients. Periods of agitation developed; and he would, on occasion, become a marked management problem—suddenly becoming extremely vocal about his delusions, combative and very hostile. Mechanical restraints or hydrotherapy increased his anger, and firmness on the part of the staff redoubled it.

At a team meeting it was decided that the patient's background indicated a deep-seated craving for attention and affection. It was decided to lavish this upon him without asking for any response from him. After about a month of this treatment, the patient began suppressing his delusional system, saying he would forget about his uncle. He was reported to hallucinate less often, and his hostile outbursts began decreasing. For one short period—when the patient was on another ward where the personnel had no contact with those who had been working with him and began to treat him firmly again—extreme rage reactions occurred. These stopped on his return to his old ward. A consistently better adjustment has been maintained for several months, and at the present time the social worker is arranging for his placement outside the hospital in an environment where he will continue to receive the warmth he needs.

. . .

In the first case, a consistently firm but kind approach to the patient was decided upon at the team conference. In application,

this enabled the patient to make considerable progress toward building a better social adjustment. The second case illustrates the accomplishment of a more limited goal. The patient's ability to suppress his symptoms and to maintain a limited adjustment outside the hospital was made possible with a completely friendly, undemanding affection and attention. In both cases, the proper management was arrived at in the conference. Its consistent application reflected the understanding of the treatment rationale at all levels of the staff.

SUMMARY AND CONCLUSIONS

Environmental treatment should be, as much as possible, oriented toward the individual patient's level of organization and therapeutic potential. The larger the patient load of a hospital and the smaller the staff, the more difficult is this ideal to achieve. Small, well-staffed hospitals have in many instances achieved it to an admirable degree. It is believed that certain elements of their treatment approach can be transplanted to the larger hospital. This involves the proper supervision of the less-trained persons who work with the patients most of the time so that they may become familiar with the elements and philosophy of relationship therapy.

Through good supervision, environmental therapy can be individualized so that the activities available in the hospital environment are exploited in ways most meaningful for the present social and psychological organization of the patient. Effective hospital treatment requires active supervision and participation of all who work with patients in diagnostic and planning conferences.

The fundamental job of the highly-trained professional person should be supervision. This is best accomplished through a traveling team organization in which a unit or units of psychiatrist, psychologist, and social worker confer regularly with the larger administrative groups of nurses, aides, and other therapeutic workers.

Two cases were cited which demonstrate the functioning of such teams.

The important goal is to permeate the institution with a therapeutic orientation and a realistic optimism based on interest in individual patients.

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REFERENCES

1. Myerson, A.: Theory and principles of the "Total Push" method in the treatment of chronic schizophrenia. *Am. J. Psychiat.*, 95:1197, 1939.
2. Fromm-Reichmann, Frieda: Problems of therapeutic management in a psychoanalytic hospital. *Psychoan. Quart.*, 16:3, 1947.
3. Simmel, E.: Psychoanalytic treatment in a sanitarium. *Int. J. Psychoan.*, 10: 70-89, 1929.
4. Adams, E. C.: Problems in attitude therapy in a mental hospital. *Am. J. Psychiat.*, 105:456-461, 1948.
5. Devereux, George: The social structure of the hospital as a factor in total therapy. *Am. J. Orthopsychiat.*, 19:492-500, 1949.
6. Bateman, J. Fremont, and Dunham, H. Warren: The state mental hospital as a specialized community experience. *Am. J. Psychiat.*, 105:445-448, 1948.
7. Menninger, William C.: Individualization in the prescription for nursing care of the psychiatric patient. *J. A. M. A.*, 196:756-761, 1936.
8. Reider, Norman: Hospital care of patients undergoing psychoanalysis. *Bull. Menn. Clin.*, 1:168-175, 1937.

SOME PROBLEMS IN THE USE OF PSYCHOTHERAPY*

BY OSCAR PELZMAN, M. D.

The following discussion is intended to express some thoughts that occurred to the writer in the course of psychotherapeutic work with individuals and with groups, mostly with psychotic patients, but also with psychoneurotic and "normal" persons.

One may observe many attitudes toward psychotherapy. There are some workers to whom psychiatry and psychotherapy are synonymous; some others reject psychotherapy completely; and others give lip service, but have a rather hostile attitude toward it. There are the extremists who feel that psychoanalysis is the only thing of value in psychiatry and others who consider the switch of the electric shock machine, or the knife of the brain surgeon final answers in therapy.

After participating in meetings and listening to arguments, where "authorities" express diametrically opposed views, one, almost by necessity, after a period of bewilderment and confusion, has either to join one school of thought or another, to gain strength from "belonging"—or one must become eclectic, and make up his own mind.

The problem of "specific" psychotherapy is one of those most frequently encountered among discussants. Closely connected with it, is the problem of interpretation. Often extremely different views are presented by the experts, and the remarkable thing is that all schools of thought show success with their therapeutic efforts; they all experience failures too, that are not much talked about. Not only the different dynamic approaches show success but also suggestive methods, religious faith healing and other kinds of treatment. The latest addition to psychotherapy is dianetics which has been thoroughly discussed and rejected by psychiatry. May it suffice to say that it is a significant reflection upon present psychiatry that dianetics could find as widespread interest among the public as it did.

In discussing the different approaches to psychotherapy one should mention the Alcoholics Anonymous movement, which has remarkable success, even if only symptomatic and in only one

*Presented at the Down-state Interhospital Conference of the New York State Department of Mental Hygiene, New York, N. Y., April 11, 1951, and at the Up-state Interhospital Conference, Syracuse, N. Y., April 25, 1951.

area. Many A. A.'s are undoubtedly still neurotic, but they are able to stay away from alcohol after other treatments have failed, and they have a certain amount of happiness and satisfaction that enables them to carry on.

It might be worth while to speculate about the reasons that lead to success with all these varied methods. Why will a certain approach lead to success in one person, while in another, with rather similar problems, the same approach might lead to failure and another method brings success. If one tries to see the problem objectively one has to come to this conclusion: Since so many different ways can lead to therapeutic success, the system alone obviously cannot be the responsible factor. It seems that a tremendous factor in success depends upon the personality of the therapist and his attitude and that just as important is the patient's own attitude and willingness.

There is a very essential difference in comparison with the usual medical treatments. If the use of penicillin is indicated, it does not make much difference for its physiological action whether the intern, the nurse or Alexander Fleming himself administers the injection. It also makes little difference whether the patient is in favor of or against the treatment. Not so with psychotherapy! This is a very delicate interpersonal relationship that easily can get out of gear.

The reasons why the whole pattern is so intricate must be numerous and complicated. An attempt to discuss them would not only be a most exhaustive undertaking but would fill a whole book. Here the writer will barely touch upon some of the points.

One factor, which seems very important to the writer, is the universal need for establishing causal relationships. This seems closely connected with the also universal struggle for security. As our feeling of security decreases, our anxiety increases, and vice versa. One may define anxiety as an unpleasant emotional state, of all degrees from uneasiness to panic, caused by more or less unconscious stimuli, originating within the individual or in his environment, and perceived as of a not well-determined, but always threatening, nature.

In the end, it is the purpose of psychotherapy to reduce or eliminate anxiety, and, in the word's widest sense, any procedure that has such effect is psychotherapy.

As has been said, the need for finding causal relationships—as it seems to the writer—originates in the universal need to reduce anxiety. Seeing the cause helps to bring order into chaos, and this in turn gives a feeling of mastery and security.

One can observe though, that it is not very important to the individual, whether the explanation *he* accepts is universally accepted if there is such a thing as universal acceptance. The interpretation that satisfies will depend upon the cultural and educational, ethical and religious background of the individual, in short upon his whole personality makeup. The writer believes that here is an important factor among the reasons why the different approaches in psychotherapy may lead to success in some cases and to failure in others.

Another factor that is neglected, especially by some purely psychodynamically oriented investigators, is that of genetic and constitutional influences upon personality development. If we think for a moment of the qualities and possibilities transmitted in the fertilized egg, we come to some staggering figures. In man there are 24 pairs of chromosomes, there are 20,000 to 44,000 genes and every gene transmits several factors. If one thinks of the impressive number of combinations possible in the mental sphere, he will become more humble and a little less sure of generalized interpretations of human behavior.

All manifestations of so-called mental aberration, from the slightest neurotic symptom to the most severe psychotic syndrome, must have their basis and start in some genetically-transmitted factor. Of course our knowledge of genetics is still extremely fragmentary, perhaps will never be sufficient to apply it therapeutically. But, to quote Boyd, "since genes manifest themselves and influence the development of the organism through changes in physiological and therefore chemical reactions, it is *theoretically* possible that the action of any gene could be controlled if we knew enough about the way it produced its effect."^{*}

Although the phenotype, physical and even more so psychological, will be influenced by environment, our way of reacting to it is influenced by our genotype, the sum of potentialities transmitted to us in our genes. Our genotypes will influence the developments of our personalities and our reactions to our environments, therefore, reactions to psychotherapeutic interventions also, if such in-

^{*}Boyd, W. C.: *Genetics and the Races of Men*. P. 91. Little, Brown. Boston. 1950.

terventions become necessary. As some proof of this, one can see some people going "through hell" without breakdowns, while others with similar backgrounds give way and break down under even favorable circumstances.

Again, we are dealing with a tremendously complicated problem, but it is with reason that one can assume, that here also factors are at play that will influence success and failure in psychotherapeutic attempts.

From a more pragmatic point of view the problem of education and re-education plays such an important part in psychotherapy that it is desirable to give some thought to it.

It appears that the biological basis of education is the employment of our ability to store our own experiences and those of others so they may be used whenever necessary in our adaptation to our life situations. It is obvious that, besides constitutional factors, it will depend largely upon our educations (in this wide sense) how well we are able to meet our tasks of living. If someone is in need of psychotherapy, it may be said that the set of tools at his disposal does not work well. It is the psychotherapist's task to show him how to become efficient with his set, or to give him new tools. The work to accomplish this will be, in great part, educational and re-educational. Success will largely depend upon the attitudes and abilities of the teacher and student. The guiding principles will be of lesser importance. Their choice will be determined to some extent by the personality make-ups of the protagonists.

As has been mentioned, men are continuously searching for security and, as one result of this, are always on the lookout for cause and effect relationships. Recognizing this fact as an important driving force in our emotional lives, we shall also see its connection with the problem of "insight." It can easily be seen that the type of insight which a patient in psychotherapy develops, will largely depend upon the school of psychiatric thought to which the therapist belongs. The writer heard Jules Masserman say in regard to insight: "We call it insight if we get a patient to see things the way we see them and we want him to see them too."

It is thus quite understandable that the patient of, let's say, a Freudian analyst will see eventually that his difficulty started when he neglected to resolve his Oedipal situation.

Someone treated by methods of dianetics will become a "clear," that is a superman regarding emotional and physical health, the moment he "remembers" in the course of his treatment, that his trouble started when he was a fetus of six weeks and his father got into a violent argument with his mother over the spoiled supper, thus giving him a terrible scare *in utero*.

As was stated in the beginning, all types of treatment show success, and all of them show failure. One common factor in them seems to be that, in the successful cases, the approach chosen by the therapist is accepted by the patient while in the failure it is rejected.

Isn't it then better—instead of adhering rigidly to one way of dealing with patients—to be a little Machiavellian and to choose the approach most suited for the case? This will require the therapist to stay flexible and eclectic.

Before concluding, the writer would like to make a remark regarding psychotherapy. As discussed, the psychological difficulties necessitating psychotherapy are the result of a combination of constitutional and environmental, organic and psychological factors. The writer believes that their diagnosis should be made by the physician, as well as the over-all treatment plan. Psychotherapy itself, he believes, can be applied by people suited for it and trained in it, regardless of whether they are physicians. As for the question of training, the writer believes that the preceptor-apprentice system will yield the best results.

The last part of this paper is dedicated to some thoughts in connection with group psychotherapy. Lately many therapists have become interested in this type of treatment, among them more and more psychoanalysts. A classic on group psychotherapy was written by a psychoanalyst, Alexander Wolf.* He talks about group psychoanalysis; but very little of the classical psychoanalytic approach remains in his technique.

The writer believes firmly that the group approach eventually will be the main technique in psychotherapy and that individual psychotherapy will serve mainly to overcome special hurdles and prepare patients for group psychotherapy. He can envisage participation in group discussion of emotional problems as a regular routine in connection with mental hygiene. The writer can see that every individual will be exposed to it in the course of emo-

*Wolf, A.: The psychoanalysis of groups. *Am. J. Psychother.*, III:4, and IV:1.

tional development and maturation, and that it will be a tremendous, even the most important, factor in development of mental health.

Individual psychotherapy is a theoretical approach, and the therapeutic session is removed from real life. The problems causing emotional difficulties are viewed, not where and when they are created, but in retrospect, and no matter how much abreaction takes place, the approach is basically more or less intellectual.

The group situation can, on the other hand, be considered a training ground, on which it is permitted to make mistakes and on which attempts to correct them can be made without risk. The patient can and will re-enact situations and attempt to master them, as a child in its play learns to master situations. The group can be made a reflection of real life and its problems, but with the dangers of real life taken away.

Another tremendous advantage of the group is that the members can act therapeutically on each other. The therapist is not forced into the role of a little god who has to "know everything best," even if he is not doing too much interpretation.

It seems to the writer that it would constitute the best type of training to be exposed to, and to participate as a member of, group meetings conducted by experienced therapists. The members work on each other, and see each other's blind spots and the neurotic trends that might cause them.

The writer personally feels that such an approach could help to develop objective and successful psychotherapists and that much more could be accomplished if persons who have the inclination and talent could themselves undergo an intense period of group psychotherapy and then put their understanding in the service of mental health on a really wide basis.

In summary, it is felt that because of certain factors, some of which are discussed, the outcome of psychotherapy can be attributed, only in a small part, to the specific system used.

Because of these factors, success can be obtained with different systems and failure can, likewise, occur with all of them.

This author stresses the importance of group psychotherapy and expresses the belief that eventually this approach will become the most important one in the fight for increased mental health.

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FINGER-PAINTING AS AN AID IN PERSONALITY EVALUATION OF 44 ADULT HOSPITALIZED MENTALLY ILL PATIENTS

BY GILBERT M. CAMPBELL, M. D., AND LEO GOLD, M. A.

Miss Ruth F. Shaw, the originator of modern finger-painting, adopted it as part of her many educational techniques. Of it she said, "Finger-paintings are the direct descendants of mud pies—all I have done is to add the rainbow."¹ Within the past decade finger-painting has been used as "a diagnostic projective technique, as a means for stimulating free associations, as a part of psychotherapy, play therapy and by occupational therapists for the rehabilitation of spastic patients, the deaf and the blind."² Perhaps the most comprehensive survey has been done by Napoli, in which he related finger-painting to personality diagnosis.

The material in this paper is considered only a preliminary report on the subject as investigated at Syracuse (N. Y.) Psychopathic Hospital among 44 adult patients. Because of the limited number of cases, no statistical validations could be made. Nevertheless, when correlated with other types of psychological investigation and with the psychiatric anamneses, certain interesting tendencies were noted which may be more fully validated in the future with a larger number of cases. The theories and hypotheses put forward in this paper are considered only as leads toward further investigation.

As a projective technique, it was felt that the painting situation for the patient should be as unstructured as possible. At the same time the patients were asked to perform under testing conditions. During the periods of painting, detailed notes were made of the patient's approach to the painting situation and of the material verbalized.

The patients, 26 men and 18 women, were all within the adult age group. Each patient received a sheet of glossy paper approximately 20 inches by 32 inches and this was wet for him. The patient was then shown the finger-paints (six colors) placed in jars to his left. It was then explained that he could use any color or colors, apply them to the paper and then make anything he chose. No demonstration was given other than one in which he was shown, without the use of paint, the various ways in which the paint could be worked onto the surface of the paper.

An attempt was made to make the testing situation as relaxed and informal as possible under the circumstances, to help the patient feel that the finger-painting was a form of play, and also to allay any fears that the work would in any way influence the attitudes of the general hospital staffs.

The patients were encouraged to complete at least three paintings during the one testing period, but no pressure was brought to bear if they resisted this suggestion. They were not asked to associate directly to the paintings, but any spontaneous verbalizations were noted. It was suggested, however, that they give titles to all pictures, and many of these were considered significant, such as: "Graph of The Glories of War" in a grandiose, male paranoid schizophrenic; "Greased Lightning" in a young male epileptic and "Mixup" in a depressed manic-depressive female. Many patients, of course, were unable to give titles to their pictures.

In interpreting the paintings and a patient's reaction to the situation, many factors were considered which are of significance in other projective techniques such as the Rorschach, T. A. T., Bender Gestalt and general psychoanalytic concepts. It is hoped that with further work it may also be possible to validate to a greater degree the hypotheses which are to be presented regarding those factors which, it is felt, might be indicative of the patient's attitudes in his interpersonal relationships.

For breakdown of the material, the cases were divided into male and female, dementia praecox, manic-depressive, psychoneurotic and organic categories.

APPROACH TO PAINTING SITUATION

The approach to the unstructured situation and the comments and questions of the patient were felt to offer a variety of insights into the patient's personality and problems. Many patients approached the situation with excessive questioning such as: "What do I do? . . . Do I have to use my hands? . . . I don't know what you mean. . . . What color should I use?" On the other hand, some asked for constant reassurance throughout the painting session with comments such as: "I can't make anything. Shall I make it all one color? What do you want me to do?" This type of behavior was fairly evenly distributed throughout the groups, with a greater frequency among the women than the men, with 13 out of 18 women reacting in this way as compared with 10 out of 26

men. This excess questioning and need for reassurance was felt to reflect a feeling of insecurity in the patients and a lack of insight in dealing with any life problems that were not completely structured for them. It was felt that these people had difficulty in dealing with reality and were consequently fearful of moving in any direction—because of the fantasied consequences of punishment or failure. Also such responses possibly reflected the need of these people for the constant support of others.

Resistance was also reflected by long pauses or periods of silent inactivity, the patients requiring repeated urging by the examiners before even an attempt at starting was evinced. This type of behavior was found most frequently among schizophrenics. Of the 34 patients who displayed this type of behavior, 15 were schizophrenic, nine psychoneurotic, five organic and five manic-depressive. This possibly indicated the development of negativistic behavior. Implied in this may have been an unwillingness to cooperate in social situations and, in a sense, an unwillingness to lend the self to activity with others.

The fear of failure or ineffectuality with the technique was another form of resistance. A subject in this case would depreciate himself stating that he was not an artist or did not know how to draw. The writers felt that this reflected not only a fear of failure but a low concept of self. Some patients indicated resistance by asserting that the examiners were trying to find out something about them. This type of reaction was found to be equally distributed among the four groups. It was felt that this might indicate the generalized reaction of these people to the motives of others, whether real or fantasied.

Five of the patients, three men and two women, expressed distaste over contact with the paint. The three males were known to be strongly latent or overt homosexuals with considerable guilt over masturbation. It was felt that this form of resistance involved the fear of being soiled, or more symbolically, of becoming contaminated or impure, and it was further postulated that anal sadistic and masochistic trends might be suspected in those who presented this attitude.

Two subjects, one a manic-depressive, manic, and the other a grandiose case of dementia præcox, paranoid, accompanied their paintings with a continual rambling conversation which jumped rapidly from one subject to another and from the pertinent to the

bizarre in a flight of ideas. This type of reaction was thought to reflect a barrier against facing the problems of reality and the repressed guilts of unconscious life.

One patient, a paranoid schizophrenic, insisted on writing out what he considered to be significant philosophical material prior to entering into the test situation. In this individual, the break from reality was pronounced. It was felt that his action symbolically indicated the precedence that the delusional aspects of the inner life had taken over the demands of reality.

An occasional patient was struck by the color of the paint, and delayed the proceeding by commenting on the color as such. It was theorized here that the same factors were operating as in Rorschach's color shock and that these people found difficulty in dealing with strong emotions.

SIGNIFICANCE OF CHOICE AND USE OF COLOR

Because of the small number of patients used in this study, few valid findings could be discovered from the initial choice of color. Only two seemingly interesting statistics could be drawn. Twice as many women as men patients preferred red. This is in agreement with Napoli's theory that red is essentially a feminine color.³ No woman used purple initially whereas four men did. The use of all the other colors, blue, black, yellow, green and brown was fairly evenly distributed between the sexes.

In use of colors, the authors have theorized specific meanings in terms of social usage, and current scientific literature. Warm colors as red and yellow have affective meanings in relating to others. They are believed to be indicators of impulsivity. The cool colors, blue and green, reflect a minimum of emotional tone and represent the reserved and controlled factors of emotional expression. Black and purple are utilized in terms of depression, with black also having in it, like red, strong elements of hostility. Brown is considered a regressive factor, indicative of fairly infantile behavior patterns. These are felt to be the basic qualities attached to each color. However, when combined with subject matter, color takes on additional significance in regard to each patient, in terms of the meanings attached to the particular color by western culture. The symbolism of green thus has, at one extreme, the meaning of youth and life when spoken of in terms of springtime, and the meaning of envy and bitterness at the other. It reflects the

concepts of growth and rejuvenation. Blue is a color frequently attached to the loftiest concepts of man in terms of nobility, purity, moral values, detachment and serenity. It may represent, in the disturbed person, an ideal which is desired but not attainable. It has magical qualities in terms of its appearance in western religion, when the Virgin is clothed in a blue robe. Since it is perhaps the color most closely related to control and high intellectual endeavor and values, the mechanism most closely related to it is rationalization. Blue is also ascribed to bodies of water and in this sense may indicate a need for emotional security.

The use of red has the indication of strong affect. Red is connected with war, violent emotion, prostitution, destruction, danger, hostility, aggression and anger in its negative phase. In its positive aspects it can reflect love, warmth, and responding emotionally to others. It is perhaps the most primitive of the colors in its expression of the grosser emotions. It may, therefore, reflect both conscious and unconscious responses of patients where strong emotions are involved. Yellow is also an affective color representing a continuum from the life-giving creative rays of the sun to the symbol of weakness and cowardice. It is a somewhat weaker affect than red, although it has in it the factors of hatred and maliciousness on a more structured level, as exhibited in its use by the Nazis during the last war.

The use of orange, a mixture of yellow and red, reflects the idea of fire, which may possibly be the source of warmth and creativity or a combination of the meanings underlying red and yellow of destructiveness, reflecting great hostility directed toward specific objects or individuals.

Brown is symbolically the color of earth and, therefore, may be interpreted as referring to earthy things. It may also suggest regression to infantile stages on an anal level.

Purple is considered to be a depressive color that has in it the more polite, less intense, qualities of mourning and death in western culture. While it may be all-pervading, it does not achieve great intensity. In its milder shades, it is also associated with old age. It may be considered a color of control in regard to the depressing factors of life, in a somewhat similar manner to the rational control attached to blue.

Socially, black reflects the concept of death in its most profound meaning. With it, one frequently associates fear, a severe sense

of loss, reactive depression, suicidal ideas, despair, hopelessness, severe anxiety, hostility toward the world, etc. It may, therefore, be theorized that a person who utilizes black primarily in his paintings is the type who is prone to attempt to resolve his difficulties and fears by a course of action on a primarily impulsive basis, without consideration of the possible consequences of his action.

SIGNIFICANCE OF AREA RELATIONSHIPS

Of the 25 paintings in which the interest and movement was toward the left, 12 were paintings of schizophrenics, eight of psychoneurotics, three of organic patients, and two of manic-depressives. Of the 18 in which interest and movement were primarily to the right, 10 were those of psychoneurotics, five of schizophrenics, three of manic-depressives and none of organics. One theorizes that when primary movements were continually toward the left or the balance of the drawing was primarily on the left, withdrawal defenses were operating in the patient in regard to interpersonal relationships. Conversely, an excess of balance toward the right could then be interpreted as an indication of overemphasis in relating to others and could be diagnostically significant in terms of fear of isolation. A well-balanced drawing, where equal weight was put on both sides was then felt to be indicative of more normally-adjusted interpersonal relationships. Thus, the left-to-right vector was theorized as the interpersonal relationship vector in this method of finger-painting.

A vertical vector was also considered in terms of the possible inference of elation-depression factors. However, in this series, there were too few cases of depression available to validate a theory. Of the eight paintings with primary movement toward the top of the page, two were painted by schizophrenics, three by manic-depressives, three by psychoneurotics. Of the 18 with emphasis toward the bottom of the page, six were those of schizophrenics, five of manic-depressives, five of psychoneurotics and two of organics. It was theorized, however, that when the greater balance of weight of the painting was toward the bottom of the page, depressive factors were in operation, and where the greater stress was on the upper part of the sheet, ebullience and elation were presumed to be present and the individual was more outgoing and hyperactive.

The use of small areas of the paper only, leaving large areas of white space, was felt to represent negativism, resistance and possibly encapsulation, and it was found that this occurred in seven of the nine paranoid schizophrenics. The philosophy involved possibly reflected an unwillingness to reveal the self to others and also the suspiciousness and hostility of the subject to the painting situation.

FORMS AND SYMBOLS UTILIZED IN PAINTING AND THEIR INTERPRETATION

The complete lack of any type of design or form in painting was felt to indicate marked resistance reflecting both an unwillingness to face one's inner problems and unwillingness to reveal one's self to others. One female paranoid schizophrenic, choosing red as her color, rubbed and re-rubbed the paint over the surface of the paper until it began to peel off. She refused to produce anything during the painting situation. The factors operating here were felt to be fear, negativism, hostility, and, of course, anxiety over, and suspicion of, the motives of the examiner.

The use of the figure three, or the juxtaposition of three forms in a varied manner, was given a sexual interpretation referring to the male genitalia—in line with psychoanalytic concepts.

Six of the subjects produced houses during the painting sessions. The house was interpreted as being symbolic of the subject's concept of self. Thus, as in the concepts utilized in the "Draw a House, Tree, Person" test, certain aspects of the painting were considered in interpretation, such as: the position of the painting on the paper, the size of the house, doorway, window and chimney detail. And turning to classical analysis, the authors felt that the painting of a house could be a symbolic representation of the mother figure. Thus, a house drawn in juxtaposition to two other forms could, apart from sexual connotations, have the additional interpretation of mother, with father and child, and could in this sense yield data regarding the Oedipal conflicts of the subject as well as his psychosexual concept of role in life.

The portraying of a tree or trees was interpreted according to meanings given such drawings, in other types of psychological testing. Initially, the portrayal of a tree related to the concept of self, especially when painted alone in its setting. The particular structure of the trunk and limbs was considered as indicative of

the feelings and attitudes of the subject. A barren denuded tree was suggestive of an individual who felt bare and exposed to the world. Rigidity in the form of the tree was felt to reflect a rigid approach to life situations and, in the sexual area, an overconcern with sexual potency.

Geometrical figures were interpreted in terms of Bender Gestalt theory, with angular forms, such as diamonds and wedges, considered masculine symbols, whereas circles, certain types of squares, ellipses or other curved figures were interpreted as female.

Animal forms were felt to have a special meaning. It was theorized that these reflected developmental problems in the early childhood of the patient and indicated to some extent, the degree to which these infantile problems were affecting his present adjustment. It was considered that dogs and horses could be interpreted as male symbols, because of the associations of these animals in our western culture. Cats could then be interpreted in terms of the female. Drawing animals from the rear with emphasis on the buttock region was felt to be suggestive, in males, of homosexual factors, with particular concern with anal activity, especially where tail emphasis was present, and also with related early childhood identification with the female figure. The animal forms were considered to reflect repressed concepts of self which could only achieve conscious expression through the parataxic distortions of the defense mechanisms.

Human forms in contrast to animal forms were felt to express a more mature concept of role in life and a more conscious awareness of the self, although these were markedly affected by the quality of the drawing, the colors utilized, and the associations and comments made by the subject. The placement of the figure on the paper was considered in terms of area relationships and was felt to be suggestive of the subject's ability to relate to others. The size reflected concept of self. Overemphasis on mouth was considered to reflect dependency. Incorporation of teeth or overlengthening of digital extremities was interpreted as hostility.

The drawing of lakes in paintings, where the lake form predominated, was felt to be suggestive of the presence of withdrawal and avoidance behavior. It was interesting to note that of the 11 paintings in which water was a subject only one was done by a manic-depressed manic, whereas six were painted by schizophrenics and four by psychoneurotics. It was felt that these painters of water

might be the people who were seeking a calm retreat from the pressures of life.

In conclusion, despite the limited number of cases, the writers feel that the diagnostic interpretations obtained from finger-painting closely paralleled information obtained from the histories and from the psychiatric and psychological investigations done at Syracuse Psychopathic Hospital. With additional research in this medium, it is felt that this technique can be a valuable addition to existing projective techniques, as well as an aid in understanding the dynamic factors operating in the therapeutic situation.

CASE ILLUSTRATION

Description of the Painting

Patient A.'s production was a Christmas tree. His initial choice of color was green. The painting was placed on the paper slightly to the left of center and ranged from the lower third of the sheet to the top edge. A. first drew the green foliage which was the major part of the painting, in a rather broad triangular form. At the base of this, he drew a red square and then outlined the square on three sides with black. He then expressed a need to decorate the tree and placed dots of red, yellow and blue on the green. His textures were thick, as he used large quantities of paint. The rest of the sheet was left uncolored. The painting was entitled, "Coming Event."

Painting Interpretation

The place of the tree on the paper (toward the left with much white space) is suggestive of a feeling of aloneness, with the pressure of negativistic factors. It is suggested that, by the isolation of the figure, feelings of rejection are present. The bottom red surrounded by the black is indicative of feelings of depression and anxiety overlaid on a repressed hostility. The choice of the tree suggests sexual preoccupation, and the decoration of it leads to the idea that exhibitionistic tendencies are present. The extensive use of green with accompanying blue is felt to indicate the use of intellectual control in handling social situations and in repressing hostile impulses. Since, however, the weighting of the green suggests overcontrol and a rather rigid personality, the defenses appear rather brittle and may break down, resulting in A.'s acting out on the basis of impulse, with little consideration for the con-

sequences of his behavior. The large size of the tree reflects his desire to play a more potent role in his life situation. He is utilizing a reactive formation mechanism, and fears of impotence are present. He has difficulty in carrying out life goals, and is easily swayed from his purpose by his inner conflicts, which reduce the utilization of his inner resources in achieving success. The handling of the paint in thick textures and the use of the spatula is indicative of the presence of obsessive-compulsive behavior. The well-integrated quality of the drawing, despite the excess of white space, leads to the conclusion that A.'s is an essentially neurotic type of personality.

Case History

A. was a 38-year-old white married man who was admitted to the hospital because of his exhibitionistic behavior. He was described as a quiet, amiable, well-dressed person. He had a history of early rejection by his parents and subsequently had been raised by relatives. His mother died when he was 10 years old, and he was separated from his father because of the latter's alcoholism. He completed second year high school at the age of 17, had had a steady work history, and was considered a valuable employee. He was married at the age of 24. Prior to marriage, actual sexual activity had consisted of masturbation, which was learned from his brother at the age of 13, although he reported several experiences with the opposite sex during adolescence. His marital sexual life had been unsatisfactory, as there had been periods of impotence which related to the several unsuccessful pregnancies of his wife. The wife is Rh negative; and, of the four pregnancies, only one was successful. As a result, A. developed feelings of unworthiness. Impotence was also related to feelings of "organ inferiority." It was during his marriage that his exhibitionistic behavior began. It was significant that his behavior manifested itself in exposing himself and masturbating before 'teen-age girls. This occurred on many occasions over a period of several years and resulted in his arrest and hospitalization. In the psychiatric report, he was described as a rigid obsessive-compulsive who repressed his aggressiveness and blamed himself for not showing more of it. He was described as being "guilt-ridden" with feelings of inadequacy. His contact with reality was considered good except for some defects in attention. He showed much depression in regard to his life situation.

SUMMARY

1. This paper is a preliminary report on finger-painting as investigated at Syracuse Psychopathic Hospital among 44 adult patients.

2. The painting situation was completely unstructured, and the performance was under testing conditions during which complete notes were taken of the subject's approach, performance, and verbalization.

3. Interpretation was according to the following aspects: (a) approach to the painting situation; (b) significance of choice and use of colors; (c) significance of area relationships in the paintings (an interpersonal, right-left vector is theorized); and (d) forms and symbols utilized and their interpretation.

4. It was felt that the interpretation of the finger-paintings yielded data about the personality of the subject which correlated well with findings obtained from psychiatric interviews and psychological evaluations.

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REFERENCES

1. Kadis, Asya L.: Finger-painting as a projective technique. In Bellak and Abt: *Projective Psychology*. P. 404. Knopf. New York. 1950.
2. Ibid.
3. Napoli, P. J.: The interpretive aspects of finger-painting. *J. Psychol.*, 23:93-132, 1947.

A STATISTICAL STUDY OF PATIENTS IN THE NEW YORK CIVIL STATE HOSPITALS, APRIL 1, 1950

BY BENJAMIN MALZBERG, Ph.D.

On April 1, 1950 there were 93,609 patients on the books of the New York civil state hospitals, the largest total in the history of the New York State Department of Mental Hygiene. The accompanying table (Table 1) summarizes the data from 1920 to 1950. It will be noted that there were increases each year from 1920 through 1942, the population growing from 38,294 to 83,092. During the nine months ended March 31, 1943, however, the number of patients on the books decreased by 520 to a total of 82,572. This was the first annual decrease in the number of such patients. During the following year, there was another decrease of 675. During the year ended March 31, 1945 the downward trend was ended, and the population increased slightly—by 197. The population increased rapidly thereafter, and the rate of growth during the last two years has been among the highest ever recorded. Between 1920 and 1930 the population of the civil state hospitals showed an average annual increase of 1,374. During the next decade there was an average annual increase of 2,678, representing the period of most rapid growth in the history of the department. Despite the two years of decrease during the decade 1940 to 1950, there was an average annual increase of 1,480 during this period. It is probable that the high rate of increase in recent years will be continued.

The number of patients on the books on June 30, 1920 represented a rate of 366.2 per 100,000 of general population. The annual rate grew steadily to a maximum of 654.4 in 1945. Population changes resulting from the war caused a downward trend in the rate, which fell to 606.9 in 1947. Subsequent changes in population in the opposite direction have brought about a rise in the rate since 1947. On March 31, 1950 the rate per 100,000 population was 631.2, which is below the maximum rate in 1945, but is higher than the rates at the beginning of the last decade.

AGE

Table 2 shows the ages of the patients on the books of the civil state hospitals on April 1, 1950. Of the 93,609 patients, only 1,384,

Table 1. Patients on the Books of the New York Civil State Hospitals*

Date	Males	Females	Number	Total Rate per 100,000 general population**
June 30, 1920	17,752	20,542	38,294	366.2
June 30, 1921	18,543	21,193	39,736	374.9
June 30, 1922	19,271	21,620	40,891	380.6
June 30, 1923	19,394	21,908	41,302	379.4
June 30, 1924	19,845	22,407	42,252	383.0
June 30, 1925	20,444	23,157	43,601	387.6
June 30, 1926	21,002	23,417	44,419	384.7
June 30, 1927	22,096	24,214	46,310	391.1
June 30, 1928	23,134	25,398	48,532	399.9
June 30, 1929	24,007	26,149	50,156	403.5
June 30, 1930	25,045	26,985	52,030	412.6
June 30, 1931	26,061	27,891	53,952	424.8
June 30, 1932	27,706	29,154	56,860	444.6
June 30, 1933	29,334	30,479	59,813	464.4
June 30, 1934	30,970	31,866	62,836	484.6
June 30, 1935	32,076	33,296	65,372	500.7
June 30, 1936	33,493	34,895	68,388	520.3
June 30, 1937	35,040	36,241	71,281	538.6
June 30, 1938	35,962	37,557	73,519	551.8
June 30, 1939	37,165	39,158	76,323	569.1
June 30, 1940	38,324	40,490	78,814	583.7
June 30, 1941	39,125	41,826	80,951	603.4
June 30, 1942	39,847	43,245	83,092	632.1
March 31, 1943	39,322	43,250	82,572	638.9
March 31, 1944	38,227	43,670	81,897	647.0
March 31, 1945	37,711	44,383	82,094	654.4
March 31, 1946	37,969	44,765	82,734	621.4
March 31, 1947	38,803	45,720	84,523	606.9
March 31, 1948	40,061	47,406	87,467	611.5
March 31, 1949	41,548	49,241	90,789	619.4
March 31, 1950	42,845	50,764	93,609	631.2

*Including Syracuse Psychopathic Hospital.

**Rates revised from 1941 to 1949, inclusive, in accordance with corrected estimates of the general population.

or 1.5 per cent, were under 20 years of age. The numbers increased rapidly with age to a maximum of 9,854, or 10.5 per cent of the total, at ages 50 to 54.

The average age of the patients on the books was 53.3 years. As usual, the male patients were younger than the females, their average ages being 51.8 and 54.5 years, respectively. A similar census of the patients according to age was taken on April 1, 1947.

72 STATISTICAL STUDY OF PATIENTS IN NEW YORK CIVIL STATE HOSPITALS

Table 2. Patients on the Books of the New York Civil State Hospitals, April 1, 1950,
Classified According to Age

Age (years)	Number			Per cent		
	Males	Females	Total	Males	Females	Total
5-9	48	11	59	0.1	*	0.1
10-14	228	89	317	0.5	0.2	0.3
15-19	512	496	1,008	1.2	1.0	1.1
20-24	1,433	1,142	2,575	3.3	2.2	2.8
25-29	2,293	2,048	4,341	5.4	4.0	4.6
30-34	2,822	2,914	5,736	6.6	5.7	6.1
35-39	3,671	3,972	7,643	8.6	7.8	8.2
40-44	4,294	4,633	8,927	10.0	9.1	9.5
45-49	4,524	4,950	9,474	10.6	9.8	10.1
50-54	4,488	5,366	9,854	10.4	10.6	10.5
55-59	4,208	5,566	9,774	9.8	11.0	10.4
60-64	4,227	5,256	9,483	9.9	10.4	10.1
65-69	3,769	4,420	8,189	8.8	8.7	8.8
70-74	2,718	3,771	6,489	6.3	7.4	6.9
75-79	1,863	2,868	4,731	4.3	5.6	5.1
80-84	1,041	1,897	2,938	2.4	3.7	3.1
85-89	460	903	1,363	1.1	1.8	1.5
90-94	149	290	439	0.3	0.6	0.4
95-99	26	52	78	0.1	0.1	0.1
100 or over	2	7	9	*	*	*
Unascertained	68	114	182	0.2	0.2	0.2
Total	42,845	50,764	93,609	100.0	100.0	100.0

*Less than 0.05.

At that time males had an average age of 51.0 years, and females an average age of 53.5 years. For the sexes combined, the average age was 52.4 years. Thus, in only three years, the average age increased by almost one year. Previous studies show that there has been a steady upward trend in the average age of patients in the civil state hospitals since 1915.

This upward trend is due primarily to an increase of patients aged 60 or over. Thus, of the 46,955 resident patients on April 1, 1930, 11,705, or 24.9 per cent, were aged 60 or over. On April 1, 1947 there were 84,523 patients on the books, of whom 28,065, or 33.2 per cent, were 60 or over. Of the 93,609 patients on the books on April 1, 1950, 33,719, or 36.1 per cent, were 60 or over.

Another comparison, Table 3, shows that the number of patients on the books grew from 84,523 on April 1, 1947 to 93,609 on April 1, 1950, an increase of 9,086, or 10.7 per cent. Those aged 60 or

over grew during the same period from 28,065 to 33,719, an increase of 5,654, or 20.2 per cent.

The marked growth in the number of patients aged 60 years or over is related in turn to the growth of the number of patients with certain types of mental disorders. Patients with psychoses with cerebral arteriosclerosis increased from 3,967 on June 30, 1935 to 7,775 on April 1, 1950. (See Table 4.) They included 8.3 per cent of the total on April 1, 1950, compared with 6.1 per cent on June 30, 1935. During the same period patients with senile psychoses increased from 1,970, or 3.0 per cent of the total, to 4,837, or 5.2 per cent. Patients with involutional psychoses increased from 1,605, or 2.5 per cent, to 4,595, or 4.9 per cent. These three groups, all of high average age, and with high percentages of those aged 60 or over, included 11.6 per cent of the total patients on the books on June 30, 1935, but included 18.4 per cent on April 1, 1950.

The average age ranged from 27.8 years at the Psychiatric Institute and 41.0 years at Syracuse Psychopathic Hospital to a maximum of 60.7 years at Willard State Hospital. All but two of the

Table 3. Patients in the New York Civil State Hospitals, Classified According to Age

Age (years)	April 1, 1930*		April 1, 1947**		April 1, 1950**	
	Number	Per cent	Number	Per cent	Number	Per cent
Under 15	77	0.2	257	0.3	376	0.4
15-19	460	1.0	889	1.1	1,008	1.1
20-24	1,498	3.2	2,342	2.8	2,575	2.8
25-29	2,663	5.7	3,968	4.6	4,341	4.6
30-34	3,855	8.2	5,595	6.6	5,736	6.1
35-39	5,143	11.0	7,464	8.8	7,643	8.2
40-44	5,703	12.1	8,449	10.0	8,927	9.5
45-49	5,609	11.9	8,963	10.6	9,474	10.1
50-54	5,330	11.4	9,130	10.8	9,854	10.5
55-59	4,854	10.3	9,226	10.9	9,774	10.4
60-64	4,076	8.7	8,503	10.1	9,483	10.1
65-69	3,195	6.8	6,837	8.1	8,189	8.8
70-74	2,180	4.6	5,434	6.4	6,489	6.9
75-79	1,358	2.9	3,883	4.6	4,731	5.1
80 or over	896	1.9	3,408	4.0	4,827	5.2
Unascertained	58	0.1	275	0.3	182	0.2
Total	46,955	100.0	84,523	100.0	93,609	100.0

*Resident patients only.

**All patients on the books.

Table 4. Patients in the New York Civil State Hospitals, Classified According to Mental Disorders

Mental disorders	June 30, 1935		June 30, 1940		April 1, 1947		April 1, 1950	
	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent
General paresis	3,454	5.3	4,017	5.1	3,776	4.4	3,726	4.0
With other syphilis of central nervous system	406	0.6	681	0.9	517	0.6	493	0.5
With epidemic encephalitis	279	0.4	342	0.4	423	0.5	450	0.4
With other infectious diseases	85	0.1	79	0.1	78	0.1	72	0.1
Alcoholic	2,405	3.7	2,945	3.7	2,604	3.1	3,577	3.8
Due to drugs or other exogenous poisons	80	0.1	82	0.1	65	0.1	91	0.1
Traumatic	365	0.6	478	0.6	501	0.6	574	0.6
With cerebral arteriosclerosis	3,967	6.1	5,524	7.0	6,432	7.6	7,775	8.3
With other disturbances of circulation	77	0.1	117	0.1	145	0.2	146	0.2
With convulsive disorders	1,310	2.0	1,652	2.1	1,726	2.0	1,856	2.0
Senile	1,970	3.0	2,608	3.3	3,711	4.4	4,837	5.2
Involutional	1,605	2.5	3,122	4.0	4,004	4.8	4,595	4.9
Due to other metabolic, etc., diseases	151	0.2	153	0.2	136	0.2	196	0.2
Due to new growth	37	0.1	58	0.1	56	0.1	79	0.1
With organic changes of nervous system	394	0.6	498	0.6	450	0.6	548	0.6
Manic-depressive	6,130	9.4	6,122	7.8	4,766	5.7	4,196	4.4
Dementia praecox	36,970	56.6	43,788	55.6	49,083	57.8	53,763	57.4
Paranoia and paranoid conditions	1,199	1.8	1,172	1.5	934	1.1	881	0.9
With psychopathic personality	873	1.3	961	1.2	978	1.2	1,005	1.1
With mental deficiency	2,263	3.5	2,740	3.5	2,937	3.4	3,287	3.5
Psychoneuroses	633	1.0	859	1.1	829	1.0	957	1.0
Undiagnosed	579	0.9	541	0.7	118	0.2	154	0.2
Without psychosis	65	0.1	47	0.1	56	0.1	64	0.1
Primary behavior disorders	20	*	178	0.2	198	0.2	297	0.3
Total	65,317	100.0	78,764	100.0	84,523	100.0	93,609	100.0

*Less than 0.05.

Table 5. Patients on the Books of the New York Civil State Hospitals, April 1, 1950
Classified According to Age

Hospitals	M.	Total F.	T.	5-9 years		10-14 years		15-19 years		20-24 years		25-29 years		30-34 years	
				M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.
Binghamton	1,625	1,424	3,049	1	..	1	..	6	10	36	19	36	46	60	48
Brooklyn	2,034	2,137	4,171	1	2	4	2	44	25	135	97	181	154	197	197
Buffalo	1,294	1,985	3,279	..	..	..	..	11	14	51	40	72	75	110	108
Central Islip	4,350	4,531	8,881	..	..	..	1	12	5	86	61	161	123	234	227
Creedmoor	2,129	3,530	5,659	..	..	..	3	18	19	69	72	118	125	160	234
Gowanda	1,894	1,754	3,648	..	..	1	..	17	16	46	33	76	58	99	83
Harlem Valley	1,998	2,985	4,983	..	..	2	1	15	17	52	38	88	79	123	154
Hudson River	2,338	2,864	5,202	..	..	..	..	9	11	45	38	95	84	123	117
Kings Park	4,942	4,801	9,743	14	4	108	47	149	212	245	207	501	302	479	337
Manhattan	1,776	2,667	4,443	..	..	1	..	3	5	61	40	84	74	93	128
Marcy	1,573	1,546	3,119	..	..	1	2	14	15	51	43	63	85	73	101
Middletown	1,771	1,933	3,704	..	..	2	..	3	4	31	21	44	34	90	61
Pilgrim	5,761	7,190	12,951	2	..	1	4	35	42	178	154	312	330	376	451
Psychiatric Institute	77	71	148	11	..	2	..	11	6	19	20	10	14	5	12
Rochester	1,682	2,121	3,803	..	..	2	..	15	7	28	52	54	88	79	114
Rockland	3,708	4,465	8,173	19	5	99	28	128	72	229	148	283	241	361	355
St. Lawrence	924	1,287	2,211	..	..	..	..	..	4	23	16	24	32	46	43
Syracuse Psychopathic	32	33	65	..	..	2	..	6	..	2	..	1	4	3	4
Utica	1,035	1,266	2,301	..	..	1	..	8	5	29	20	54	46	60	75
Willard	1,902	2,174	4,076	..	..	2	..	8	7	16	22	36	54	51	65
Total	42,845	50,764	93,609	48	11	229	88	512	496	1,432	1,141	2,293	2,048	2,822	2,914

Table 5. Patients on the Books of the New York Civil State Hospitals, April 1, 1950
Classified According to Age—(Continued)

Hospitals	35-39 years		40-44 years		45-49 years		50-54 years		55-59 years		60-64 years		65-69 years	
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.
Binghamton	86	83	134	103	132	128	167	133	175	165	207	160	229	153
Brooklyn	200	233	203	211	158	166	147	173	151	168	155	161	131	121
Buffalo	144	148	145	168	122	161	132	209	114	211	132	214	104	171
Central Islip	346	326	467	448	537	518	517	550	475	582	498	498	420	337
Creedmoor	252	320	286	396	236	403	213	411	200	389	195	352	150	233
Gowanda	157	136	206	149	201	170	217	207	211	190	188	167	159	141
Harlem Valley	172	237	214	284	248	325	239	362	219	413	195	323	186	237
Hudson River	194	186	216	237	225	256	254	279	234	345	236	313	244	285
Kings Park	462	438	423	458	451	466	570	482	584	478	405	400	235	301
Manhattan	95	175	144	195	176	210	160	247	190	238	173	227	176	272
Mary	97	131	132	116	165	118	157	155	181	158	181	164	169	134
Middletown	136	102	181	140	195	152	164	197	193	224	203	236	195	218
Pilgrim	540	608	675	766	757	850	676	880	544	845	549	758	428	572
Psychiatric Institute	10	9	2	8	3	2	1	..	1	..	1	..	..	..
Rochester	135	120	133	158	166	191	156	186	178	236	183	241	192	187
Rockland	419	482	454	521	415	514	371	478	217	448	239	371	180	287
St. Lawrence	51	64	68	75	89	97	84	116	97	148	90	147	102	138
Syracuse Psychopathic	4	5	5	5	5	3	2	1	2	3	..	3	..	4
Utica	81	94	94	94	95	104	103	143	91	142	109	123	100	113
Willard	89	76	112	101	148	116	158	157	151	183	288	418	369	446
Total	3,670	3,972	4,294	4,633	4,524	4,950	4,488	5,366	4,208	5,566	4,227	5,256	3,769	4,420

Table 5. Patients on the Books of the New York Civil State Hospitals, April 1, 1950,
Classified According to Age—(Concluded)

Hospitals	70-74 years		75-79 years		80-84 years		85-89 years		90-94 years		95-99 years		100 years or over		Unascertained	
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.
Binghamton	163	143	107	103	50	74	23	42	10	8	1	2	..	..	1	4
Brooklyn	118	140	91	122	67	93	32	41	13	23	4	7	..	..	2	2
Buffalo	68	161	48	127	22	107	17	54	1	12	1	4	..	..	..	1
Central Islip	258	331	197	240	94	133	35	58	8	19	..	3	1	1	4	20
Creedmoor	101	237	71	162	36	99	15	52	6	21	1	..	..	..	2	2
Gowanda	121	151	102	112	64	73	19	45	6	12	..	1	..	..	4	10
Harlem Valley	119	202	57	144	33	88	21	34	10	11	..	2	..	3	5	11
Hudson River	188	283	145	210	76	139	34	54	10	16	2	5	1	..	7	6
Kings Park	143	250	95	221	49	128	14	45	8	16	1	1	..	..	6	8
Manhattan	160	264	134	229	77	194	30	119	12	36	4	4	..	1	3	9
Marcy	142	145	76	101	44	52	17	20	7	5	..	1	..	..	3	..
Middletown	139	195	101	148	54	128	25	49	6	14	..	2	..	..	9	8
Pilgrim	313	417	204	282	113	161	42	68	11	17	1	2	..	1	4	2
Psychiatric Institute .....	..	..	1	..	..	..	..	..	..	..	..	..	..	..	..	..
Rochester	150	186	104	160	61	100	29	57	14	28	1	7	..	1	2	2
Rockland	126	226	83	147	53	90	21	39	7	9	..	1	..	..	4	3
St. Lawrence	101	136	56	126	47	81	27	40	8	17	5	1	..	..	6	6
Syracuse Psychopathic .....	..	..	..	1	..	..	..	..	..	..	..	..	..	..	..	..
Utica	82	94	71	102	28	60	24	38	4	10	..	3	..	..	1	..
Willard	226	210	120	131	73	97	35	43	8	16	5	6	..	..	7	21
Total	2,718	3,771	1,863	2,868	1,041	1,897	460	903	149	290	26	52	2	7	70	115

Table 6. Patients on the Books of the New York Civil State Hospitals, April 1, 1950, Classified According to Age and Mental Disorders—(Continued)

	35-39 years		40-44 years		45-49 years		50-54 years		55-59 years		60-64 years		65-69 years		70-74 years	
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.
General paresis	103	78	251	137	438	184	471	184	451	166	360	142	266	84	107	60
With other syphilis of central nervous system	15	14	24	13	38	27	36	35	43	31	51	28	24	24	20	14
With epidemic encephalitis	42	43	49	36	43	26	31	16	10	13	11	6	3	2	2	..
With other infectious diseases .....	..	1	1	4	3	6	1	5	1	3	3	2	3	2	..	1
Alcoholic	115	92	222	102	326	135	399	143	399	127	432	129	340	78	160	43
Due to drugs or other exog. poisons ..	..	8	1	3	6	7	7	12	6	11	6	3	2	1	..	4
Traumatic	31	7	28	8	54	9	61	14	64	8	81	7	34	7	32	8
With cerebral arteriosclerosis	1	..	3	4	13	18	67	60	200	191	503	480	851	808	841	959
With other disturb. of circulation ..	2	3	7	2	6	8	15	20	10	21	5	17	7	6	1	4
With convulsive disorders	109	122	105	102	107	117	80	84	68	91	86	79	44	44	29	27
Senile .....	..	..	..	1	..	1	..	6	4	13	30	65	153	256	304	555
Involutional	1	15	7	109	52	310	167	614	282	849	291	759	210	463	96	194
Due to other metabolic, etc., dia. ..	1	3	3	8	2	11	15	23	13	30	14	21	7	13	2	5
Due to new growth .....	..	1	5	2	6	4	7	4	7	3	5	2	4	4	1	2
With organic changes of nervous system	25	20	35	28	35	36	42	28	36	29	35	30	13	19	8	5
Manic-depressive	50	196	98	287	125	323	154	411	169	427	177	377	172	322	121	236
Dementia praecox	2,901	3,057	3,173	3,488	3,021	3,387	2,657	3,374	2,209	3,194	1,915	2,804	1,434	2,040	852	1,446
Paranoia and paranoid conditions ..	6	5	16	22	14	31	32	48	42	56	52	72	59	78	54	86
With psychopathic personality	63	26	57	37	34	49	39	41	31	54	36	32	30	23	8	25
With mental deficiency	145	188	156	178	145	199	149	181	119	198	93	159	72	104	56	71
Psychoneuroses	47	84	40	57	46	52	43	48	33	41	31	38	28	36	13	25
Undiagnosed	5	5	4	5	6	7	11	12	10	8	8	4	11	5	10	1
Without psychosis	6	3	9	..	4	3	4	3	1	..	2	..	1	1	..	..
Primary behavior disorders	2	1	..	..	..	..	..	..	..	2	..	..	1	..	1	..
Total	3,670	3,972	4,294	4,633	4,524	4,950	4,488	5,366	4,208	5,566	4,227	5,256	3,769	4,420	2,718	3,771

Table 6. Patients on the Books of the New York Civil State Hospitals, April 1, 1950, Classified According to Age and Mental Disorders—(Concluded)

	75-79 years		80-84 years		85-89 years		90-94 years		95-99 years		100 years or over		Unascertained	
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.
General paresis	47	23	13	7	3	4	1	1	..	..	..	..	2	3
With other syphilis of central nervous system..	14	8	2	2	..	..	..	..	..	..	..	..	..	..
With epidemic encephalitis	1	..	..	..	..	..	..	..	..	..	..	..	1	..
With other infectious diseases .....	..	1	..	..	..	..	..	..	..	..	..	..	..	..
Alcoholic	96	30	16	17	5	3	1	1	..	1	..	..	4	3
Due to drugs or other exogenous poisons	1	..	..	2	..	..	..	1	..	..	..	..	..	..
Traumatic	17	5	6	..	1	..	1	..	..	..	..	..	..	1
With cerebral arteriosclerosis	685	761	368	475	151	207	42	52	3	3	..	2	16	11
With other disturbances of circulation	2	..	1	2	..	..	..	..	..	..	..	..	..	..
With convulsive disorders	12	10	2	6	2	1	..	1	..	..	..	..	..	1
Senile	405	817	385	826	206	492	79	177	14	33	2	2	2	9
Involuntal	42	78	10	27	3	8	..	1	..	..	..	..	1	5
Due to other metabolic, etc., diseases	2	2	..	..	..	..	..	..	..	..	..	..	..	..
Due to new growth	3	4	2	3	..	..	..	..	..	..	..	..	..	..
With organic changes of nervous system	2	1	2	1	2	..	..	..	..	..	..	..	1	..
Manic-depressive	44	129	21	45	9	25	3	3	..	2	..	..	2	5
Dementia præcox	436	869	181	409	68	133	20	43	9	12	..	2	37	71
Paranoia and paranoid conditions	18	69	14	59	4	24	1	6	..	..	..	1	..	2
With psychopathic personality	10	11	2	4	3	..	..	2	..	..	..	..	..	1
With mental deficiency	17	38	10	19	2	3	1	..	..	1	..	..	..	3
Psychoneuroses	7	11	5	3	..	2	..	1	..	..	..	..	1	..
Undiagnosed	1	1	1	1	1	1	..	1	..	..	..	..	3	..
Without psychosis	1	..	..	..	..	..	..	..	..	..	..	..	..	..
Primary behavior disorders .....	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Total	1,863	2,868	1,041	1,897	460	903	149	290	26	52	2	7	70	115

hospitals showed an increase in the average age of patients since the previous census. In general, patients in the upstate hospitals have higher average ages than those in the downstate area. This is due in large part to the transfer of chronic patients to relieve overcrowding in the metropolitan area. Age groups by hospitals are shown in Table 5, by diagnostic categories in Table 6.

DURATION OF RESIDENCE

Table 7 summarizes the patients on the books according to the number of years of residence since their last admissions. Thus, of the 93,609 patients, 16,109, or 17.2 per cent had been on the books for less than a year. Those resident for less than five years totaled 40,535, or 43.3 per cent, whereas those resident five years or over totaled 53,074, or 56.7 per cent. Those with residences of 25 or more years totaled 10,713, or 11.4 per cent.

The median duration of residence was 7.2 years. Males and females had median durations of 7.1 and 7.3 years, respectively. The median durations ranged from a minimum of 0.7 years among those without psychosis to a maximum of 11.3 years among patients with dementia præcox.

Table 7. Patients on the Books of the New York Civil State Hospitals, April 1, 1950, Classified According to Duration of Residence

Years	Number			Per cent		
	Males	Females	Total	Males	Females	Total
Under 1 year	7,682	8,427	16,109	17.9	16.6	17.2
1	4,618	5,408	10,026	10.8	10.7	10.7
2	2,829	3,431	6,260	6.6	6.8	6.7
3	2,002	2,420	4,422	4.7	4.3	4.7
4	1,653	2,065	3,718	3.9	4.1	4.0
5-9	6,429	7,849	14,278	15.0	15.4	15.3
10-14	5,604	6,747	12,351	13.1	13.3	13.2
15-19	4,491	5,069	9,560	10.4	10.0	10.2
20-24	2,848	3,324	6,172	6.6	6.5	6.6
25 or over	4,689	6,024	10,713	10.9	11.9	11.4
Total	42,845	50,764	93,609	100.0	100.0	100.0

Table 8 shows the patients on the books classified by duration of residence since last admissions, according to diagnostic categories.

Table 8. Patients on the Books of the New York Civil State Hospitals, April 1, 1950,
Classified According to Duration of Residence

Mental disorders	Total		Under 1 year		1 year		2 years		3 years		4 years		5-9 years	
	M.	F.	T.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.
General paresis	2,584	1,142	3,726	289	132	205	100	153	62	150	61	140	53	541
With other syphilis of con. nerv. sys.	281	212	493	27	31	27	13	22	16	9	17	10	7	59
With epidemic encephalitis	260	190	450	23	29	22	15	13	17	11	12	18	6	60
With other infectious diseases	31	41	72	8	7	7	8	1	5	2	..	2	2	7
Alcoholic	2,612	965	3,577	756	291	468	174	268	112	152	54	162	43	364
Due to drugs or other exogen. poisons	34	57	91	10	31	4	12	4	1	3	..	1	1	3
Traumatic	478	96	574	91	20	68	13	47	8	30	3	21	5	94
With cerebral arteriosclerosis	3,744	4,031	7,775	1,137	1,208	663	719	461	459	277	252	212	247	610
With other disturbances of circulation	62	84	146	21	24	12	16	10	6	2	6	2	8	9
With convulsive disorders	930	926	1,856	139	122	92	90	64	78	63	48	48	49	202
Senile	1,584	3,253	4,837	556	983	330	665	211	508	129	294	105	192	183
Involutional	1,162	3,433	4,595	381	843	208	495	83	244	66	172	49	164	169
Due to other metabolic, etc., diseases	63	123	186	26	34	12	17	10	18	4	12	3	8	4
Due to new growth	47	32	79	15	13	11	4	5	5	3	1	2	..	8
With organic changes of nervous sys.	299	249	548	71	54	44	41	26	28	24	22	23	12	60
Manic-depressive	1,216	2,980	4,196	269	534	137	284	78	152	54	144	47	119	165
Dementia precox	24,407	29,356	53,763	3,166	3,423	1,964	2,363	1,127	1,466	848	1,170	682	994	3,404
Paranoia and paranoid conditions	317	564	881	42	41	25	21	16	29	18	18	14	22	58
With psychopathic personality	498	507	1,005	169	111	77	69	45	42	29	30	16	26	47
With mental deficiency	1,487	1,800	3,287	159	188	125	159	98	125	76	74	71	65	320
Psychoneuroses	399	558	957	186	233	60	111	31	29	18	22	10	31	37
Undiagnosed	89	65	154	21	22	19	5	10	5	5	4	5	7	11
Without psychosis	46	18	64	37	10	2	2	3	1	..	..	..	2	1
Primary behavior disorders	215	82	297	83	43	36	12	43	15	28	4	10	2	13
Total	42,845	50,764	93,609	7,682	8,427	4,618	5,408	2,829	3,431	2,002	2,420	1,653	2,065	6,429

Table 8. Patients on the Books of the New York Civil State Hospitals, April 1, 1950,
Classified According to Duration of Residence—(Continued)

Mental disorders	10-14 years		15-19 years		20-24 years		25-29 years		30-34 years		35-39 years	
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.
General paresis	500	226	370	141	176	73	37	36	16	9	6	8
With other syphilis of central nervous system	43	30	54	25	19	17	6	4	4	5	1	2
With epidemic encephalitis	54	36	38	24	19	13	2	3	..	..	..	..
With other infectious diseases	2	5	1	5	..	..	1	1	..	..	..	..
Alcoholic	194	94	126	32	65	26	24	9	17	7	8	7
Due to drugs or other exogenous poisons	8	7	1	2	..	..	..	1	..	..	..	..
Traumatic	68	19	32	6	18	5	4	..	2	..	2	..
With cerebral arteriosclerosis	256	274	106	123	13	31	8	4	..	2	..	..
With other disturbances of circulation	2	4	2	2	1	..	..	..	..	1	..	1
With convulsive disorders	129	153	96	70	51	61	24	28	13	19	5	3
Scmile	46	120	15	36	8	7	1	3	..	..	..	..
Involutional	134	597	50	129	17	46	3	21	2	6	..	3
Due to other metabolic, etc., diseases	2	12	1	2	..	2	..	2	..	1	..	..
Due to new growth	2	2	1	1	..	..	..	1	..	..	..	..
With organic changes of nervous system	24	18	19	12	5	6	3	1	..	..	..	..
Manic-depressive	146	467	161	348	79	221	43	154	17	85	13	39
Dementia praecox	3,640	4,194	3,198	3,774	2,236	2,612	1,517	1,917	1,151	1,382	677	778
Paranoia and paranoid conditions	46	118	26	47	23	43	16	42	18	27	9	30
With psychopathic personality	40	40	24	61	23	19	12	17	6	15	10	5
With mental deficiency	230	296	157	200	90	136	59	104	50	62	20	28
Psychoneuroses	28	30	13	28	3	6	8	5	1	4	..	2
Undiagnosed	7	3	..	1	2	..	5	2	..	2	1	..
Without psychosis	1	2	..	..	..	..	..	..	..	..	2	1
Primary behavior disorders	2	..	..	..	..	..	..	..	..	..	..	..
Total	5,604	6,747	4,491	5,069	2,848	3,324	1,773	2,355	1,297	1,627	754	907

Table 8. Patients on the Books of the New York Civil State Hospitals, April 1, 1950,
Classified According to Duration of Residence—(Concluded)

Mental disorders	40-44 years		45-49 years		50-54 years		55-59 years		60-64 years		65-69 years	
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.
General paresis .....	..	2	..	..	..	..	1	..	..	..	..	..
With other syphilis of central nervous system .....	..	1	..	..	..	..	..	..	..	..	..	..
With epidemic encephalitis .....	..	..	..	..	..	..	..	..	..	..	..	..
With other infectious diseases .....	..	..	..	..	..	..	..	..	..	..	..	..
Alcoholic	8	5	..	2	..	..	..	1	..	..	..	..
Due to drugs or other exogenous poisons .....	..	..	..	..	..	..	..	..	..	..	..	..
Traumatic	1	..	..	..	..	..	..	..	..	..	..	..
With cerebral arteriosclerosis .....	..	..	1	..	..	..	1	..	..	..	..	..
With other disturbances of circulation .....	..	..	..	..	..	..	..	..	..	..	..	..
With convulsive disorders	1	12	2	5	..	..	1	..	1	..	..	..
Senile .....	..	..	..	..	..	..	1	..	..	..	..	..
Involutional .....	..	..	..	1	..	1	..	..	..	..	..	..
Due to other metabolic, etc., diseases	1	..	..	..	..	..	..	..	..	..	..	..
Due to new growth .....	..	..	..	..	..	..	..	..	..	..	..	..
With organic changes of nervous system .....	..	..	..	..	..	..	..	..	..	..	..	..
Manic-depressive	5	21	1	6	1	6	..	1	..	..	..	..
Dementia praecox	440	502	218	297	98	126	32	57	8	13	1	6
Paranoia and paranoid conditions	3	21	1	6	2	2	..	..	..	..	..	..
With psychopathic personality .....	..	1	..	..	..	..	..	..	..	..	..	..
With mental deficiency	13	20	10	8	4	8	5	..	..	..	..	..
Psychoneuroses	3	..	..	..	..	..	1	1	..	..	..	..
Undiagnosed	2	..	1	..	..	..	..	..	..	..	..	..
Without psychosis .....	..	..	..	..	..	..	..	..	..	..	..	..
Primary behavior disorders .....	..	..	..	..	..	..	..	..	..	..	..	..
Total	477	585	234	325	105	143	40	62	8	14	1	6

SUMMARY

There were 93,609 patients on the books of the New York civil state hospitals on April 1, 1950. Between 1920 and 1942 the number of patients had increased from 38,294 to 83,092. During the next two years, however, the population declined to 81,897. This departure from the upward trend over many preceding years was undoubtedly related to population changes brought about by World War II. During the year ended March 31, 1945 the number of patients increased slightly, and in the succeeding years the rate of growth has again been high.

The average age of the patients on the books on April 1, 1950 was 53.3 years. Males and females had averages of 51.8 and 54.5 years, respectively. The average age has been advancing steadily, because of the increase of patients aged 60 or over. This, in turn, is related to the steadily increasing number of admissions of patients with psychoses with cerebral arteriosclerosis, senile psychoses, and involutional psychoses.

The patients on the books on April 1, 1950 had an average residence of 7.2 years since their last previous admissions.

Division of Statistics

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PRELIMINARY REPORT OF THE INTRODUCTION OF GROUP PSYCHOTHERAPY ON A CHRONIC WARD IN A MENTAL HOSPITAL

BY GERDA P. WILLNER, M. D.

During the month of May 1951, the writer was confronted with the problem of selecting a number of patients for group psychotherapy in one of the chronic women's wards of Central Islip (N. Y.) State Hospital. Because of lack of close acquaintance with the patients, it was thought best to include a few intelligent-looking younger women, who seemed to be genuinely interested in the undertaking. In addition, a few dull-looking and apparently deteriorated individuals, who seemed to be able to listen without creating too much disturbance, were also chosen for the group. Since it was planned to apply psychotherapy on a superficial level, a heterogeneous group was formed and not too much attention was paid to the diagnosis. A few alcoholics and psychoneurotics and a larger number of fairly well-preserved schizophrenics were included.

The first session was held in the large visiting room of one of the buildings. Twenty young women were seated comfortably around a large table, helping themselves to cigarettes which were provided for them. They all glanced curiously and somewhat suspiciously at the new woman doctor. They did not ask questions and seemed to be only mildly interested in the proceedings. A few women even expressed disappointment about being kept from going out to the field and the commissary as they usually did during the morning hours of this particular day of the week.

The session was started with a few introductory words as to the purpose of the bi-weekly meetings, stressing the fact that it was hoped it would be easier to face one's own shortcomings and mistakes if one saw them in other people, and that insight was one step closer to cure. A little elaboration was made on the symptoms of a so-called nervous breakdown, and it was stressed that quantity rather than quality of symptoms and actions constituted mental disorder.

During the first halves of the following 15 sessions, brief introductory lectures were given on the subjects of mental hygiene and the prevention of the outbreak of mental disease; on the subject

of the conscious and unconscious mind, the formation of the ego and the conscience, the significance of forgetting, slips of the tongue, and printing errors; and on dream symbolization and its interpretation. Later some of the most important mental mechanisms were discussed, such as rationalization, sublimation, repression, identification, and projection and, finally, symptom formation, with definitions of delusion, illusion and hallucination.

In the beginning, the patients did not participate at all. They sat apathetically through the session, listening politely but never asking any questions. Invitations to discussion met with an icy reserve. They merely smoked a few cigarettes; and, when asked to write their names on the attendance list, quite a few would remark that they would rather not sign their names on any official paper. They kept apologizing for leaving the room frequently in order to go to the bathroom, and they wanted to be excused because they had letters to write. Or they would develop sudden headaches. The discussion during the second half of the session also failed to awaken any interest in them. When called by name, the patients would blush and stammer and had nothing to offer. It was discouraging for the therapist to see the apparent lack of interest and the mildly-disguised hostility of these so-called better patients.

At a following session, members of the group were asked to read aloud a few selected paragraphs of Strecker's book *Beyond the Clinical Frontiers*.¹ A patient read a report about "wolf-children" to the group; on the basis of this description, the therapist pointed out the influence of human society on the development of the mind. Then there was an attempt to call a few recent reports in the daily newspapers to the patients' minds—stories about illegitimate children who were found in attics, chained to beds, and unable to walk and to talk. The therapist selected patients whom she knew to be the mothers of young children and urged them to discuss the problem of toilet-training and the development of proper eating habits in their children. A rather lively discussion about nursery problems ensued. The patients wandered away from the original topic, but only mild attempts were made to lead them back to it. During the next session, the patients were quite anxious to continue with the previous topic and they also inquired about Strecker's textbook, asking the therapist to pick out another interesting chapter. The one about crowd-minded behavior was

selected, and one of the patients read aloud some paragraphs about mass hypnosis. The patients took special interest in the chapter dealing with the appearance of a comet that spelled all sorts of things in fiery letters in space. They read rather enthusiastically about an episode of an imaginary gas poisoning in a battlefield area, and discussed the circumstances which made the minds of the exhausted soldiers so readily accessible to mass-hypnosis.

They began to ask questions, and it was decided that a cigar-box should be placed at the table and each woman should write her questions down before the beginning of the session without signing her name to the paper. The slips were to be placed in the empty box and volunteers were asked to read the questions aloud and to discuss them with other members of the group.

At first the patients were unable to formulate questions intelligently. Questions such as, "When can we go home, doctor?" appeared by the dozens, followed by questions such as, "How far is it from Central Islip to New York?" and, "How much does a train ticket cost?" Great pains were taken to explain to the patients that they would be able to go home as soon as their improvements were found to be steady and lasting. The procedures necessary to arrange for a convalescent status were pointed out to them. The next variety of question was the rather irrelevant one. Such questions apparently did not belong to therapeutic sessions topics, such as, "What is the difference between a suit, a gown and a dress?" It was noticed, nevertheless, that the patients enjoyed answering those questions; and the therapist decided to be as lenient as possible and to assume a more passive role during the discussion period.

The time devoted to free discussion increased, and the time devoted to lectures decreased, but not because the patients were less interested. Just the opposite held true. The patients now offered active suggestions as to choice of material for lectures!

A brief outline of the history of psychiatry was read from the textbook of Henderson and Gillespie,² supplemented by articles from current magazines depicting old-time mental hospitals such as Bethlem in England and the colony system in Belgium.

Chapters about superstition and witchcraft in medieval Germany were discussed by an intelligent young woman who used to be a history teacher.

Freud's introductory writings on psychoanalysis³ became a favorite source of material for public discussion; and dream-analysis threatened to absorb almost too much interest in the younger patients. They would not stop offering examples of their dream productions, and often arrived at rather startling conclusions.

Chapters from books on psychosomatic medicine (by Weiss and English,⁴ and by Flanders Dunbar⁵) evoked great interest. The patients talked freely about "organ-language" and surprised the therapist with questions such as, "Doctor, is my headache due to my unhappy marriage?" and, "Is my fatigue caused by my inability to make decisions?" The patients readily produced and interpreted examples taken from everyday language such as: "Getting a load off one's chest," "inability to stomach the situation," and "losing one's heart."

After each group session, patients would beg for personal interviews which were, of course, willingly granted. An attempt was made to give individual psychotherapy in addition to the group psychotherapy and each individual's problems were discussed with her in the doctor's office. It was frequently stressed that anybody not genuinely interested in the group meetings could drop out without offering explanation or apology. On the other hand, new patients were invited to participate; and the therapist was surprised to see that only three patients dropped out during the last four months, while about a dozen new ones joined, increasing the members of each of the two groups to about 25.

During one of the last sessions prior to writing this article, one of the patients begged the doctor to be allowed to dramatize one of the traumatic episodes in her life. The group had recently talked about the method of psychodrama, and the patient was most anxious to dramatize the incident when she had tried to get her parents interested in her new boyfriend. The patient, an intelligent manic-depressive in her manic phase, insisted upon playing her own part in the scene, suggested that the therapist perform her domineering mother's part and named another young woman to re-enact her spineless and unimpressive father's part. She begged her parents in the most urgent way to give up a social meeting to meet the boy, who was scheduled to go overseas with the army soon. The mother showed her nothing but laughing contempt. Her weak but good-natured father voiced timid objections but was finally persuaded by the mother to join her for her social

obligations; whereupon the patient indulged in a crying spell but felt much relieved thereafter, saying that this had cleared the atmosphere for her.

Another patient asked to be allowed to re-enact her first visit as a young bride to her mother-in-law's house. Her husband had failed to free himself from the apron-strings and seemed to be dominated by his adored mother. The bride had felt inferior and was overshadowed by this glorious mother-in-law. She gave a dramatic performance of a stormy interview between a young inexperienced wife and a hostile and sarcastic woman. The part of the mother was performed really splendidly by an 18-year-old colored girl.

This same girl volunteered to re-enact a scene on a public bus in New York, when her brother had shamed her by slapping her face publicly and the conductor had asked them politely but firmly to get off at the next stop.

Ever since this session, "psychodrama" became a permanent part of the psychotherapeutic group's meetings.

Group discussions would develop readily and spontaneously and the therapist felt that she had achieved her goal almost completely when one of the youngest members reported: "Doctor, today while waiting for you to start the session we decided to start ourselves—without a doctor. We discussed all sorts of things and we got along very well; but we were sure glad when you showed up in the end! What's your opinion about our problems?" The patient then described the problems of the group to the doctor.

One morning, a middle-aged, intelligent patient, suffering from paranoid schizophrenia, knocked at the doctor's office door and brought up the topic of music therapy for patients. This patient was personally interested in what she called "vocal expression," for she had a fine singing voice and could play the piano rather expertly. She offered to play some hymns and old-time songs if words and music could be obtained for her. The Central Islip's physical training department was asked to lend its 24 volumes of hymns and some "white song cards," each one containing a dozen well-known songs such as, "Home on the Range," or "When Irish Eyes Are Smiling." Permission was given to the musical patient to use the piano for an hour before each group meeting; and, very soon, a fine chorus was established. The patients sang with much

enthusiasm and an amazing restraint; they never became too noisy nor did they transgress any rules.

In addition, they surprised the therapist by reciting poetry spontaneously at the end of each musical session; and it was not long before they composed little songs themselves. They also wrote about two dozen poems, some of which were published in the *Central Islip Hospital News*, a newspaper edited and printed by the patients. A mimeographed booklet containing the rest of these poems will soon appear.

To close, the writer wants to report that since May 1, 1951, the beginning of the group sessions, she was able to send five of the 50 participants in the group sessions out on convalescent status. They all have stayed out rather successfully, with two of them writing regularly to the therapist and to some of the members of their former groups.

SUMMARY

In May 1951 the writer was confronted with the problem of selecting patients for group psychotherapy on one of the chronic wards of Central Islip (N.Y.) State Hospital.

1. A heterogeneous group consisting of 20 young women was assembled and bi-weekly sessions were held in the large visiting room of one of the chronic buildings. Later on, a second group was started.

2. The first session was started with a few introductory words about the purpose of the meetings and about the symptoms of a "nervous breakdown."

3. During the first half of the following 15 sessions, brief lectures were given on mental hygiene and the prevention of mental disease; on the conscious and unconscious mind; on the formation of the ego and the conscience and the significance of forgetting, slips of the tongue and printing errors; and on dream symbolization and interpretation. Finally, there were talks on some of the most important mental mechanisms and on symptom formation, with definitions of delusion, illusion and hallucination. The second halves of the sessions were devoted to group discussions.

4. At the seventeenth session, members of the group were asked to read aloud selected paragraphs from Strecker's *Beyond the Clinical Frontiers*. The chapters about "wolf-children" and about crowd-minded behavior and mass hypnosis were read and discussed. The question of the influence of human society on the de-

velopment of the mind gave rise to further discussion on nursery problems (toilet training, eating habits).

5. Patients began to write questions which were placed in an empty cigar-box and which were read and answered immediately by group members.

6. More books and articles were introduced to the group. A brief outline of the history of psychiatry from the textbook of Henderson and Gillespie was given and articles about old-time mental hospitals were read. Freud's *A General Introduction to Psychoanalysis*; and the books on psychosomatic medicine by Weiss and English, and Dunbar evoked great interest.

7. An increased demand for individual interviews arose among the members of the group. Individual psychotherapy was added to the group psychotherapy. Only three patients dropped out, while a dozen new ones joined. This increased the number of members of each group to 25.

8. Psychodrama was introduced; and, during this first attempt at dramatizing, three different patients re-enacted three traumatic episodes of their lives. After this, psychodrama became a permanent part of the group meetings.

9. Music therapy was started with the help of one of the group members who had a fine singing voice and played the piano expertly. Patients formed a chorus and sang hymns and old-time favorites during the hour preceding each group session. They also started composing little songs, and they wrote about two dozen poems.

10. Since May 1951, five of the 50 participants of the group have been sent out on convalescent status, and all of them stayed out rather successfully.

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REFERENCES

1. Strecker, Edward A.: *Beyond the Clinical Frontiers*. Norton. New York. 1940.
2. Henderson, D. K., and Gillespie, R. D.: *A Textbook of Psychiatry*. Oxford University Press. London. 1948.
3. Freud, S.: *A General Introduction to Psychoanalysis*. Garden City Publishing Company. 1935.
4. Weiss, E., and English, O. S.: *Psychosomatic Medicine*. Saunders. Philadelphia. 1944.
5. Dunbar, F.: *Emotion and Bodily Disease*. Columbia University Press. New York. 1938.

WHAT THE PSYCHIATRIC NURSE SHOULD BE EDUCATED TO DO*

BY MARION E. KALKMAN, R. N.

Changing concepts in psychiatry have brought changing concepts of what the psychiatric nurse should do. If the psychiatric nurse is to play a meaningful role in the treatment of the psychiatric patient, if she is to become a fully accepted member of the psychiatric team, her functions must be defined. One must consider the particular contributions which the psychiatric nurse can make to the care of the patient. What can the nurse do for the patient that cannot be done by the psychiatrist, the social worker, or the psychologist? Why is she needed to complete the psychiatric team?

The writer would like to suggest, in the light of modern psychiatric therapy, the areas in which the psychiatric nurse can profitably function, and the goals toward which psychiatric nursing education should be directed. It seems to the writer that these functions can be grouped into four principal areas. These are: (1) the psychiatric nurse as a scientific observer, (2) the psychiatric nurse as the creator of a therapeutic environment, (3) the psychiatric nurse as a socializing agent, and (4) the psychiatric nurse as a psychotherapeutic agent. We may now discuss briefly what the nurse can be educated to do in each of these areas.

I. THE PSYCHIATRIC NURSE AS OBSERVER

The psychiatric nurse is in a unique position to be an excellent observer of the psychiatric patient because: (1) she sees the patient for longer periods than does any other member of the psychiatric team, (2) she sees him in a great variety of situations (eating, sleeping, visiting with relatives, recreational activities, post-interview situations, etc.), she sees him in moments of stress, and in moments of relaxation, (3) she stands in a more informal relationship to him and hence is less threatening to him than the psychiatrist or psychologist, and (4) by means of her courses in psychopathology, clinical psychiatry and her instruction in charting, she can be educated to become a scientifically-trained observer, aware of what she is seeing and its possible significance not only to her own work but to the other members of the psychiatric team.

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This function of observation, the psychiatric nurse has long performed. However, newer concepts of psychiatry demand that the psychiatric nurse expand and develop her powers of observation to include the more subtle nuances of the patient's behavior, such as changes of facial expression, hesitancies, slips of speech, etc. She also should be taught to observe or record her own feelings and behavior as well as that of the patient, and to describe the context in which a given act of behavior or a remark occurred, what led up to it and what followed it in order to give a complete picture of the patient's behavior. Various techniques for observing and recording group action and other types of interpersonal relationships are also becoming increasingly important. The realization that psychiatric patients do not function in a social vacuum but act in response to the people and situations in which they find themselves makes it necessary for the nurse to learn techniques of group recording.

II. THE PSYCHIATRIC NURSE AS THE CREATOR OF A THERAPEUTIC ENVIRONMENT

There is one area in the treatment of the psychiatric patient which is receiving increasing attention, that is, the creation of an environment which is specially designed to meet the emotional needs of the patient. The studies of Moreno,¹ Spitz,² Bettelheim and Sylvester,³ Cameron,⁴ Szurek,⁵ Simmel,⁶ and Fromm-Reichman⁷ indicate the importance of the role of the environment in the institutional care of psychiatrically-disturbed children and adults. The job of creating this therapeutic environment is primarily the function of the nurse. The psychiatrist may indicate what he considers would be desirable in an environment, but the achievement or failure of his goals depends upon the skill, inspiration, and resourcefulness of the nurse.

The creation of a therapeutic environment includes both physical and psychological aspects—that is, a therapeutic environment is one which, by its comfort and attractiveness, and also by the emotional climate generated within it, stimulates the patient to his maximum effort to get well. In regard to the physical aspects, it seems to the writer that psychiatric nurses need to be taught to appreciate their responsibility for active efforts to make their wards as livable as possible. Too often, the natural homemaking impulses of the nurse have been stifled by her experience in the

general hospital, where every effort is made to keep the patient's environment as impersonal as possible.

In psychiatric nursing, one needs to teach the nurse to use her natural feminine homemaking impulses to make her wards more attractive to her patients and to make her job more satisfying to herself. Also, there is no good reason why each ward in an institution should look identical, be painted the same color, be equipped with the same furniture as every other ward. The writer visited one psychiatric institution where every ward and all the corridors were painted buff, and another where everything was pale green. Neither color was unattractive by itself, but the total effect was depressingly monotonous. There seems to be no good reason why each ward should not be furnished according to the needs of the patients who are to be treated on that ward and why each ward should not have an individual character of its own.

The psychological aspects of the environment are even more important to the patient. It is the nurses who are logically the people who should be responsible here. Yet this is not generally recognized as the province of the nurse. Devereux and Weiner⁸ have stated this problem very well: "The fact remains that, to all practical purposes, the hospital today is still, all too often, an emotionally sterile climate—less so in progressive psychiatric and pediatric wards, more so in certain tradition-bound medical wards. Where the patient receives any narcissistic supplies at all, it is usually the task of everyone except the nurse to provide them. It is the job either of volunteer workers from non-professional organizations or else of social workers, etc., to give the patient needed narcissistic gratification, and the like. As to the nurse, the affect, or emotional support, which she may dispense is often viewed as something probably unnecessary, and certainly as something almost unprofessional."

Yet the nursing personnel of a given ward, in spite of present limitations, often do create an emotional climate which can be sensed instantly by the new patient or the visitor the moment he steps in the ward door. The existence of this emotional climate should be recognized and nurses should be taught to utilize it as a therapeutic approach.

Some of the elements which go into the creation of a psychotherapeutically beneficial environment may be described as feelings of friendliness, graciousness, of relaxation, warmth, and com-

fort, but for most patients, they all add up to one thing—the feeling of security which they experience. Security is one of the prerequisites for most psychotherapy. When a patient feels threatened and insecure, it is difficult for him to co-operate with his treatment. Another important aspect of a therapeutic environment is that it is one in which the patient can afford to act contrary to ordinary social behavior without being exposed to ridicule or resentment—an emotional climate where possibly for the first time he can express long-repressed, unacceptable thoughts and feelings without fear of retaliation from others. Moreover, this psychological environment is emotionally neutral. Here he can live and talk and behave without provoking a reaction in someone who is emotionally involved in his problems, as his mother, wife, or child. The nurse can afford to be permissive, yet at the same time objective. More effort, it seems, should be directed in psychiatric nursing education to teach the psychiatric nurse how to create a therapeutic environment. Also more flexibility and understanding of the importance of environment in psychiatric treatment are needed in administrative circles to allow the nurse to carry out this function of her work. Some examples of the flexibility of administrators which may be cited are, the granting of permission to nurses to wear play clothes on a children's ward, to allow a pet kitten on an old ladies' ward, to let a ward of adolescent girls decorate their own rooms in any way they choose, to arrange for nurses to eat family style with the children.

III. THE PSYCHIATRIC NURSE AS A SOCIALIZING AGENT

The next area where the psychiatric nurse can be taught to perform a unique service for the psychiatric patient is in the everyday problems of living. Many psychiatric patients have difficulty in meeting the ordinary demands of everyday life. Some of the more regressed have difficulties with problems of eating, dressing, caring for their personal needs. The nurse has always been taught to help the patients with these difficulties. But there are other needs which the nurse can meet. For the patient who is socially shy and insecure, who has always found it difficult to make friends, or for the patient who, as his mental illness progresses, becomes isolated, hostile and suspicious of others, the psychiatric nurse can perform real service. Many patients, hating themselves, consider themselves socially awkward, unattractive, stupid, and boring to

others, and, in truth, they often appear so. But a good nurse learns to look for the potentially healthy social human being behind the mask of his illness. The nurse's acceptance of her patient, and then her gradual efforts toward social motivation, showing the unattractive woman how to make the most of her general appearance, listening attentively to the man who believes himself boring, teaching the awkward adolescent to dance, can be therapeutic in the best sense of the word. The nurse needs to be taught that this is her job. She should learn how to do it, knowing what she is doing, and why, under the guidance of the psychiatrist and her own supervisors, and not haphazardly and blindly, as she and well-meaning volunteers have so often done in the past.

To prepare her for this, she needs herself to have a knowledge of social techniques, and a working knowledge of occupational and recreational therapy, and she should be encouraged to use her imagination in applying these principles and techniques with her patient. It is for this reason that the writer has always felt that, as preparation, a background in liberal arts is more important for the psychiatric nurse than one primarily consisting of science courses, a practice so prevalent in most collegiate nursing programs. It is more important for the psychiatric nurse to be able to appreciate other cultures, customs, and ways of thinking than to have a knowledge of organic chemistry or physics when it comes to the problem of understanding the psychiatric patient and helping him to readjust to more comfortable ways of living.

This brings up another important aspect of the education of the psychiatric nurse. She cannot help her patient to a happier, healthier, social life unless she herself is socially well adjusted. This means that nursing education should include in the program adequate social and recreational opportunities for the student nurse. It also means individual counseling and assistance for those students whose personal lives have been deficient along these lines. A nurse cannot give a patient what she does not possess herself.⁹ Also, as the nurse experiences the widening of her own horizons, she becomes more aware of the therapeutic effects that activities such as dancing, dramatics, singing, art projects, sports, education have for the patient. Every psychiatric hospital could be a school for living for both staff and patients.

IV. THE PSYCHIATRIC NURSE AS A PSYCHOTHERAPEUTIC AGENT

One may now discuss the role of the nurse as a psychotherapeutic agent, and her education and preparation for this aspect of her work. This is to turn from the function of the nurse in assisting the patient in his interpersonal relationships—which has been discussed in the preceding paragraphs—to the way in which she can assist with his intrapersonal difficulties. In spite of the fact that psychiatrists and nurses themselves have been reluctant to recognize that the nurse should enter into any psychotherapeutic situation whatever, the nurse, nevertheless, consciously or unconsciously, has played an important role, sometimes helping, sometimes hindering the patient's psychotherapeutic progress. The writer believes the Menningers^{10, 11} first drew attention to the fact that anyone who was in contact with a psychiatric patient could help or hinder psychotherapy. No one can deny that anyone who spends as much time with the psychiatric patient as the nurse does, can fail to have some effect upon him. This has been borne out by the amount of time patients spend in interviews with their psychiatrists discussing the nursing personnel.

Therefore, it seems only sensible for both the psychiatrist and the nurse to recognize the existence of the nurse in the psychotherapeutic situation and then to determine how she shall function, and what her limits are—then teach her how to perform this function in a way that will be most beneficial to the patient. Nursing psychotherapy should never be independent, but always under the supervision of the patient's psychiatrist. This should be a basic principle taught to the psychiatric nurse. The corollary of this is that the psychiatrist should realize how important it is for him to give the nurse such information as she must have to work intelligently with the patient. Frieda Fromm-Reichmann states,⁷ "Nurses have greater tolerance and less fear of difficult patients if they are kept alert to the dynamics of the patients' psychopathology in terms of progress or retardation as the case may be."

There are various ways a nurse may be taught to function psychotherapeutically:

1. She may carry out specific psychotherapeutic orders of the psychiatrist. An example of this would be instructions for all nursing personnel on how to handle certain critical situations in a patient's behavior, such as tantrums, panic attacks, outbursts of rage.¹² Such orders provide for a continuity of the psychiatrist's

attitude or philosophy to cover those times when he cannot be present to deal with a problem.

2. She may participate in conferences with the psychiatrist, social worker, and psychologist, and contribute to the knowledge of the psychiatric team in determining a plan of treatment which could be correlated in all the professional areas.

3. She may provide a new or missing emotional experience in the patient's life. For example, a patient who has lacked any emotional warmth from maternal figures may experience this for the first time in his relations with the nurses on the ward. This can work profound changes in a patient's personality, as for example, a child who begins to speak for the first time as the result of prolonged periods of contact with a particular nurse on the ward.

4. The nurse may provide a corrective emotional experience. For example, a patient who in his previous experiences has always been rejected in a given situation, may exhibit marked personality changes when a nurse is able to convince him of her acceptance of him.

Another way in which the nurse can be taught to function psychotherapeutically is that of role-playing, which is described by Cameron in his book, *General Psychotherapy*.⁴ It has been noted that patients are often attracted to a certain nurse and will respond to her when other nurses and patients seem to have no meaning for them. The attraction frequently develops into a relationship; and, when this relationship is analyzed, it becomes evident that that patient has projected upon this nurse, feelings and ideas which he feels for some one involved in his emotional conflict. In other words, he projects a role, that of mother, sister, wife, upon the nurse and expects responses from her similar to those of the original person. When the psychiatrist and the nurse become aware of this, this relationship can often be used by the psychiatrist to further his psychotherapy of the patient.

Some psychiatrists in the course of psychotherapy find it desirable to introduce a secondary therapist into the psychotherapeutic situation. This often occurs when it seems necessary for the patient to have two parental figures in the therapy situation, as a male and female psychiatrist as mother and father figures; or when the therapist feels the patient needs more hours of therapy than the psychiatrist is able to give him, a problem commonly solved with a psychiatrist and social worker, or a psychiatrist and

psychologist; or where the secondary therapist is able by his special skills to work with the patient in a specific area, as a psychiatrist and an art or music therapist. Up to the present time, nurses have not been used very much in this way, but there seems no good reason why, with adequate training and supervision, they should not be used. Nurses could be valuable therapeutic collaborators—particularly where prolonged periods of contact with therapeutic figures are desirable, as is true in cases of children with behavior disorders and also in those of acutely psychotic patients where the ego structure is too weak to maintain the patient unaided between sessions with his psychiatrist.

Finally, nurses can be taught to participate in several kinds of group psychotherapy. Ward discussions between patients and nursing staff have proved most satisfactory in a number of institutions.¹³ Nurses seem to be the natural and logical persons to help patients with intra-ward tensions. It has been found that such discussions do not interfere with the interviews which the patient has with his own psychiatrist but that, on the contrary, they allow him to discuss his deeper personal problems, since the irritations focused around ward-living have already been taken care of.

In some large institutions where the problems of maintaining sufficient numbers of therapists seem insuperable, some psychiatrists are training groups of nurses in simple principles of group psychotherapy.¹⁴ A nurse then has a group of patients with whom she works under the supervision of the psychiatrist. In this way, the psychiatrist can treat a far larger number of patients indirectly than he could possibly do otherwise. Here again the nurse is being used as an extension of the influence of the psychiatrist.

There has been some well-justified concern in some psychiatric circles about the question of psychotherapy by nurses, social workers, and psychologists. Nurses, an extremely conservative group professionally, have on the whole, avoided the issue by refusing to have anything to do with anything labelled "psychotherapy," except in rare instances where they have been prodded by some psychiatrist. Yet because of this attitude, psychiatric patients are not receiving as good psychiatric nursing care as they should. This is because the potentialities of the psychiatric nurse have not been explored, because psychiatric nursing educators have not equipped nurses for the newer and far more difficult functions of psychiatric

nursing, and also because psychiatrists have not known what psychiatric nurses could be expected to do and have not demanded that they give the assistance of which they are capable.

Yet as Dr. Paul Haun¹⁵ stated in a recent article in the *American Journal of Psychiatry*, "The psychiatrist welcomes the skilled services of the nurse, the social worker, or the psychologist in whom he can have confidence, whose prior training and experience he has reason to believe are sound and into which he is welcome to inquire; whose professional role is clear and who will give him ungrudging assistance within an indicated field of competence." It seems to the writer that the way to make the nurse more effective in the care of the psychiatric patient is to explore those areas where she, better than anyone else, might be able to help the patient; to clarify her professional role for her; and to give her guidance and support in this role. This means that psychiatric nursing educators will have to equip her with skills not demanded of psychiatric nurses of the past. It will also mean closer collaboration between psychiatrist and nurse both in understanding each other's psychiatric philosophy and also in working out together the details of individual patient care.

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REFERENCES

1. Moreno, J. L.: *Who Shall Survive?* Nervous and Mental Disease Publishing Co. Washington, D. C. 1934.
2. Spitz, Rene A.: Hospitalism—an inquiry into the genesis of psychiatric conditions in early childhood. In: *Psychoanalytic Study of the Child*. Vol. I, p. 53. International Universities Press. New York. 1945.
3. Bettelheim, B., and Sylvester, E.: A therapeutic milieu. *Am. J. Orthopsychiat.*, 18:191, April 1948.
4. Cameron, D. Ewen: *General Psychotherapy—Dynamics and Procedures*. Grune & Stratton. New York. 1950.
5. Szurek, S. A.: Dynamics of staff interaction in hospital psychiatric treatment. *Am. J. Orthopsychiat.*, 17:652, October 1947.
6. Simmel, E.: Psychoanalytic treatment in a sanitarium. *Int. J. Psychoan.*, 10:70, 1929.
7. Fromm-Reichmann, Frieda: Problems of therapeutic management in a psychoanalytic hospital. *Psychoan. Quart.*, 16:325, 1947.
8. Devereux, G., and Weiner, F.: The occupational status of nurses. *Am. Sociological Rev.*, 15:682, October 1950.

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9. Menninger, W. C.: Opportunities in nursing for a satisfying life. 54th Annual Report of League of Nursing Education, p. 157, 1948.
10. —, and McColl, I.: Recreational therapy as applied in a modern psychiatric hospital. *Occ. Ther. and Rehab.*, 15, February 1937.
11. —: Psychiatric hospital treatment designed to meet unconscious needs. *Am. J. Psychiat.*, 93:347, September 1936.
12. —: Individualization in the prescription for the nursing care of the psychiatric patient. *J. A. M. A.*, 106:756, March 7, 1936.
13. Gelbman, Frank: Nurse-patient discussion groups. *Mod. Hosp.*, 74:83, March 1950.
14. Hargreaves, A. A., and Robinson, A. M.: The nurse-leader in group psychotherapy. *Am. J. Nurs.*, 50:713, November 1950.
15. Haun, Paul: Psychiatry and ancillary services. *Am. J. Psychiat.*, 107:102, August 1950.

CORRELATION OF CLINICAL IMPROVEMENT OF INTENSIVELY TREATED PSYCHONEUROTICS WITH CHANGES IN CONSECUTIVE RORSCHACH TESTS*

BY EDMOND LIPTON, M. D., AND MILDRED CERES, M. A.

This study concerns itself with a group of 11 veteran patients seen in the Mental Hygiene Out-Patient Clinic of the Brooklyn Regional Office of the Veterans Administration. They had intensive psychotherapy and manifested clinical improvement in varying degrees. Patients were chosen for intensive treatment on the basis of (a) amenability to such an approach, (b) severity of symptoms and danger of regression if left untreated, and (c) strength of motivation for therapy. These factors were assessed in terms of the clinical judgment of the therapist, based on the initial psychiatric examination and on Rorschach findings.

It has generally been the practice of the senior author to request Rorschach tests at the onset of therapy, and retests, when indicated during the course of treatment, to provide more objective evaluations of improvement, or lack of improvement. An investigation of the relationship between degree of clinical improvement and degree and quality of Rorschach "improvement" appeared to be desirable. It was in this manner that the present study was undertaken.

Anyone who does therapy with a large group of patients in an out-patient setting, will find that there are certain ones with whom, for a variety of reasons, he finds himself working more intensively. It is not coincidence that these are the patients who seem to be responding. The psychiatrist surveyed those patients who belonged to this latter group, and they were all included in the study. There were 11 such subjects. All were males aged 25 to 35, and were considered by the authors to be in the "mixed psychoneurosis" group diagnostically.

Schizoid features were present in the clinical pictures or in the Rorschach records of many, but these features did not seem to alter the character structures basically or affect significantly the

*Reviewed in the Veterans Administration and published with the approval of the chief medical director. The statements and conclusions published by the authors are the result of their own study and do not necessarily reflect the opinions or policy of the Veterans Administration.

amenability to therapy of the subjects. Two had been previously diagnosed schizophrenic. There were no so-called psychopaths in the group, though one patient (Case 6) was an overt homosexual who presented anxiety and depression as his chief complaints. Hysteria in the form of somnambulism was the major symptom in one case (Case 10). The only presenting symptoms were anxiety, depression and psychosomatic disturbances, with the exception of this one hysterical patient. The Wechsler-Bellevue Adult Intelligence Scale, Form I, had been administered to nine of the 11 patients. The average intelligence quotient was 118.

Although an attempt was made to see patients weekly or oftener, this could not always be done under the usual conditions of out-patient clinic practice. Therefore, treatment could not be so "intensive" as was originally hoped. The word "intensive," when applied to psychotherapy, usually implies interpretation on a deeper level as well as frequent sessions. In the group under discussion, the compromises which were made were in terms of frequency of visits rather than in depth. The authors feel that the term "intensive" is, thus, appropriate as used by them. The period during which therapy was conducted varied from about two to four years. The number of one-hour sessions ranged from 30 to 165 hours, with 81 as an average number of hours.

The techniques of therapy utilized included direct interpretation of dream and fantasy material, interpretation of the transferences and resistances, and a very limited amount of free association, usually in relation to dream material. Interpretations were made, not only on a characterological and interpersonal level, but also on Oedipal and pre-Oedipal levels as they related to the patient's present and past experiences. Interpretations of paintings, drawings, and doodlings proved very valuable in one case (Case 2).

PROCEDURES IN EVALUATING THERAPEUTIC CHANGES

The psychiatrist's evaluation of improvement was based upon his clinical observation and judgment. This is made up of many factors. A patient's recital of symptoms and his account of the manner in which he gets along with other people are of great importance. Then there are those impressions, some of them of a rather intuitive nature, which the therapist gains through observation of the patient in the clinical situation, as well as those insights which are gained from deeper material that is indicative of

changes in basic attitudes. The degree and quality of improvement as observed by the psychiatrist are presented later for each of the improved cases in terms of (a) changes in initial symptoms, i. e., anxiety, depression, somatic complaints, (b) changes in attitudes to self and others, (c) changes in level and quality of adjustment socially and at work.

The psychologist used the comparison of successive Rorschach tests as her means of gauging the effectiveness of therapy. This test was generally administered at the onset of treatment. The two exceptions are discussed in the notes on Cases 1 and 2. The Rorschach was repeated after 12 to 20 months of treatment, and for five of the 11 patients, there was a third administration—approximately 14 months after the second test. Both quantitative and qualitative comparisons and studies were made on the Rorschachs given to each patient.

To get an objective and quantified picture of Rorschach changes occurring between test and retest, the Munroe Inspection Technique was utilized.¹ This is a check list covering the major scoring categories used in Rorschach analysis. Each category has a range of variation which is more or less arbitrarily considered "normal." An entry is made only when a Rorschach scoring deviates from these "normal" limits. This is then considered a sign of maladjustment. The total score is the sum of the number of entries, and this sum then becomes an index of maladjustment. This check list has been considered the "most useful set of signs available."²

Each of the 27 Rorschachs of the 11 improved patients was scored in this manner (see accompanying table). The mean composite score on the Munroe check list on the first Rorschach administration to all the 11 improved patients was 16.4 (standard deviation 4.0). For the second Rorschach administration to the entire group it was 11.5 (standard deviation 2.6). Upon applying the Fisher t-test to the mean difference between composite scores on the Munroe check list of Rorschach I and Rorschach II, an 0.05 level of confidence was found.³ This means, of course, that an improvement of this magnitude could have occurred by chance only five times in 100.

The same calculations were made for the five members of the improved group who had the Rorschach examination three times. For the first administration of the Rorschach, the mean was 15.6 (standard deviation 2.1); for the second administration, the mean

Munroe Check List Scores of All Patients

Improved patients	Rorschach		
	I	II	III
1	16	11	12
2	19	14	8
3	14	13	8
4	20	12	..
5	17	11	..
6	23	16	..
7	12	9	..
8	9	7	..
9	16	10	11
10	13	9	8
11	21	15	..
Mean	16.4	11.5	..
Mean of patients receiving test three times	15.6	11.4	9.4

Unimproved patients	Rorschach	
	I	II
A	22	22
B	14	12
C	12	13
D	21	24
E	25	20
Mean	18.8	18.2

was 11.4 (standard deviation 1.8); and for the third administration, the mean was 9.4 (standard deviation 1.7). For the differences of these three mean scores the Fisher t-test indicates the following levels of confidence: between first and second administration 0.01, between first and third administration 0.01, between second and third administration 0.20.

In making this quantitative comparison, it was felt desirable to include a group of five patients who had received varying amounts of treatment, but who were considered unimproved by the psychiatrist. This group of clinically unimproved patients showed a mean composite score on the Munroe check list of 18.8 (standard deviation 4.9) on the first Rorschach administration, and a mean of 18.2 (standard deviation 4.8) on the second Rorschach administration. The Fisher t-test indicated that the mean differences were at the 0.20 level of confidence; that is, not statistically significant.

Thus the Munroe check list shows a significant decrease in the number of signs of maladjustment for the total improved group and reveals no significant change in the number of signs of maladjustment for the unimproved group. An interesting finding is noted in the comparisons of the mean differences of the group receiving three Rorschachs. Whereas the mean differences between Rorschachs I and II, and between Rorschachs I and III in this improved group are found to be highly significant, the mean differences between Rorschachs II and III are insignificant. This would seem to indicate that the decrease in signs of maladjustment, as measured by the Munroe check list, occurs in the early stages of successful treatment.

That the Rorschach reflects improvement would seem to be demonstrated clearly in a quantitative way by the preceding analysis. In order to compensate for the fact that a predominantly quantitative approach to the Rorschach generally glosses over the finer nuances which are so meaningful in actual clinical practice, the Rorschachs of the improved group were studied qualitatively in the usual fashion so that these less-measurable aspects could be evaluated. The Rorschach is generally presumed to assess the intellectual and emotional functioning of the personality. More specifically, the areas measured by the Rorschach are considered to be the efficiency of intellectual functioning, quality of thinking, range of interest, emotional responsiveness, reactivity to inner and outer stimuli, attitude toward self, and attitude toward environment.^{4,5} No one sign or pattern of signs adequately covers any one of these areas. Interpretations for each of these areas are made from assessment of the interrelationships of all the signs and patterns and it is in this manner that the Rorschachs were interpreted. Comparisons of interpretations between Rorschachs I and II—and between II and III when applicable—were made. These follow in detail.

As the psychologist realized that in making these qualitative evaluations her judgment might perhaps be biased and subjective, another psychologist (R. M.), who did not know the subjects and had never seen their test material, received copies of Rorschachs I and II of nine of the subjects from both the improved and unimproved groups without any identifying data, i. e., patient's name, age, etc. He was requested to pair the nine sets of Rorschachs to determine roughly the improved and unimproved sets. He suc-

ceeded in the pairing with 100 per cent accuracy; that is, all individual subjects were correctly identified in matching the earlier Rorschachs with the later ones. In determining the improved or unimproved status of each of the nine subjects, he considered one member of the unimproved group improved and one of the improved group unchanged (Case 7). His judgment of the status of the other seven pairs agreed with the original psychologist's.

PSYCHIATRIC AND PSYCHOLOGICAL EVALUATION OF PATIENT'S CHANGE IN STATUS

The 11 improved patients are discussed individually in the following from the psychiatric and psychological viewpoints. In the interest of simplicity and economy of space, only the differences are listed (rather than a summary of case history and progress and complete Rorschach protocol interpretation). The psychiatric evaluation considers the patient's present status as compared with the condition he presented at the onset of intensive therapy. The psychological evaluation compares the differences between Rorschachs I and II and Rorschachs II and III. The first Rorschach was administered at the onset of therapy unless otherwise indicated.

CASE 1

Age: 28. Number of sessions: 115.

A. *Psychiatric Evaluation*: Clearing of severe anxiety and guilt. . . . Emergence of masculine self-concept and aggressiveness, but the patient is still hedonistic. He no longer sponges on married women. . . . Abandonment of passivity and dependence. . . . Previously unable to work, he is now working. Still some lack of ambition.

B. *Psychological Evaluation*: (First Rorschach done after several months of therapy, and at that time acute symptoms were mostly cleared.) *Changes* between Rorschachs I and II (test interval 14 months). Low drive. . . . More realistic, concrete and conforming. . . . Diminution of obsessive thinking and concern with non-essentials. . . . Excessive lability in response to external stimulation has given way to greater emotional stability and integration, concomitant with emergence of increased fantasy life. . . . Less tension. . . . Less preoccupied with sex, less hostile, less immature. . . . Has developed capacity for adult relationships.

Changes between Rorschachs II and III (test interval 13 months). Still low drive. . . . No demonstrable tension. . . . More sensitive to environment. . . . Over-intellectualizes. . . . More self-assertive and sensitive to others. . . . Passive-aggressive conflict is present.

CASE 2

Age: 35. Number of sessions: 95. I. Q.: 126.

A. *Psychiatric Evaluation:* (Treatment stopped because patient went out of town.) Clearing of moderate depression and moodiness. . . . Headaches less frequent. . . . Less tendency to over-intellectualize. . . . Less impulsive. . . . Much more capable of warm relationships. . . . Less dependent. . . . Emergence of artistic talent. . . . In general, more adaptive and realistic.

B. *Psychological Evaluation:* (First Rorschach administered prior to course of ECT, in another clinic; the patient was then diagnosed as schizophrenic. Second Rorschach done 20 months later at onset of intensive therapy.) *Changes between Rorschachs I and II (test interval 20 months).* Thinking better organized and more concrete. . . . The patient has become over-intellectualized. . . . More artistic leanings. . . . Diminution in diffuse anxiety, irritability and depression. . . . Still over-indulgence in fantasy. . . . Some diminution of feelings of being detached, withdrawn, hopeless, inadequate, guilt-ridden and hostile. . . . Emergence of socially-adaptive behavior. *Changes between Rorschachs II and III (test interval 13 months).* Less over-intellectualized, more realistic and concrete. . . . Though still anxious, better-integrated emotionally. . . . Better balance between fantasy life and affective responsiveness. . . . Recognition of dependency needs. . . . Fearful of intimate relationships but has developed capacity for greater warmth. . . . Still strong feelings of inadequacy and passivity.

CASE 3

Age: 32. Number of sessions: 108.

A. *Psychiatric Evaluation:* Marked diminution in depressive moods and obsessive thinking. . . . Somewhat warmer relations to others. . . . Less stubborn. . . . Less sadism. . . . Less inhibited sexually.

B. *Psychological evaluation: Changes between Rorschachs I and II (test interval four months).* Essentially few changes. . . . Persistence of rigidity, obsessiveness, anxiety and self-absorption. . . . Marked sexual preoccupation. . . . Some interest in people but avoids close contact. *Changes between Rorschachs II and III (test interval 20 months).* Increased conformity with group thinking. . . . Obsessive trends persist. . . . Still rigid but shows more capacity and willingness to expose self to emotional stimuli and to respond to them. . . . Generally better-integrated emotionally. . . . Basic attitudes to self and others unchanged. . . . Still much self-absorption.

CASE 4

Age: 25. Number of sessions: 40. I. Q.: 121.

A. *Psychiatric Evaluation:* Onset of illness following loss of eye in combat. . . . Marked diminution of severe anxiety, depression, insomnia, and neurotic drinking. . . . Diminution of masochism and fears of inadequacy. . . . Now able to work. . . . Still masochistic and dependent.

B. *Psychological Evaluation: Changes between Rorschachs I and II (test interval 18 months).* Increase in conformity of thinking. . . . Better emotional control based upon greater spontaneity and intellectual control. . . . Diminished feelings of inadequacy. . . . More socially adaptable. . . . Still overly passive.

CASE 5

Age: 32. Number of sessions: 55. I. Q.: 125.

A. *Psychiatric Evaluation:* Clearing of moderate anxiety, abdominal pain and diarrhea. . . . Much improved in regard to introspective, ruminative thinking. . . . Improvement in regard to feeling childish, inadequate and dependent. . . . Improved sexual adjustment. . . . Increased ego strength. . . . Engages in many activities but is not functioning efficiently.

B. *Psychological Evaluation: Changes between Rorschachs I and II (test interval 10 months).* Increased activity on a compulsive basis. . . . Thinking more individualized due to emergence of fantasy material. . . . Marked decrease in tension. . . . Less labile. . . . Greater insight into passive-aggressive conflicts and dependency needs. . . . Disinterest and avoidance of people changed to an anxiety-ridden relationship, though he always showed capacity for emotional rapport.

CASE 6

Age: 27. Number of sessions: 94. I. Q.: 116.

A. *Psychiatric Evaluation*: Severe anxiety, at times verging on panic with suicidal thoughts. . . . He showed much improvement, with only occasional depressive moods. Decrease in irritability. . . . An overt homosexual, who was in much conflict about it, he was more accepting of his homosexuality, concomitant with the assumption of a masculine role in his relations with others. . . . Much improved work capacity and adjustment in an artistic, highly competitive field. . . . He is still immature and over-emotional.

B. *Psychological Evaluation*: *Changes* between Rorschachs I and II (test interval 20 months). Still working below capacity. . . . Much energy absorbed in fantasy. . . . Increased regard for conventional ways of thinking, but paranoid elements persist. . . . Decrease in tension, withdrawal and depression. More integrated response to emotional stimuli. . . . Still in turmoil over role conception. . . . Because of increased feelings of security, he is less hostile and more realistic in his attitude towards others.

CASE 7

Age: 32. Number of sessions: 53. I. Q.: 114.

A. *Psychiatric Evaluation*: Improvement in symptoms of anxiety and depressive symptoms. . . . Improvement in regard to varied physical complaints. . . . Better sexual adjustment. . . . Greater awareness of, and a diminution in his tendency to establish, sado-masochistic patterns with his wife and others. . . . Improved job adjustment. . . . Better able to handle a severe marital problem.

B. *Psychological Evaluation*: *Changes* between Rorschachs I and II (test interval 12 months). Decrease in paranoid dereistic thinking, with an increase in conventional, practical thinking of an obsessive, ruminative quality. . . . Better emotional control. . . . Decrease in anxiety and depression. . . . Strong passive-aggressive conflict persists. . . . Socially adaptable.

CASE 8

Age: 25. Number of sessions: 30. I. Q.: 129.

A. *Psychiatric Evaluation*: Previously diagnosed schizophrenic. . . . Had brief therapy and was somewhat improved. . . .

Decided to go abroad to study for the summer. . . . Was much improved on return. . . . Anxiety, headaches, severe pain in teeth, shyness, feelings of inadequacy all cleared. . . . Upon return from Europe, felt confident, aggressive and had realistic plans for work and study. . . . Possibility of the improvement being based on a change in a cyclothymic personality should be borne in mind.

B. *Psychological Evaluation: Changes* between Rorschachs I and II (test interval 18 months). Intellectual functioning always adequate, with a compulsive quality. . . . Thinking less dereistic and more objective and conventional. . . . Broadening of range of interest more reflective of superior intellectual capacities. . . . Increased spontaneity and emotional integration. . . . Better acceptance of abilities and limitations. . . . More objective approach to people but not much capacity for warmth.

CASE 9

Age: 29. Number of sessions: 165. I. Q.: 117.

A. *Psychiatric Evaluation: Diminution* in anxiety and depression. . . . Clearing of dizziness and tinnitus. . . . Diminution of hypochondria, death fears and feelings of unreality. . . . More confidence. . . . Better job adjustment. . . . Main problem remains in his difficulty in relinquishing his dependence.

B. *Psychological Evaluation: Changes* between Rorschachs I and II (test interval 29 months). Increase in personalized elements in thinking, with greater scope of interest. . . . Decrease in tension, anxiety and impulsivity. . . . Depressive moods persist. . . . Some decrease in feelings of inadequacy, dependency and sexual guilt. . . . Though still fearful of emotional involvement, able to make superficial identification with others. *Changes* between Rorschachs II and III (test interval 11 months). Greater self-control and increased sensitivity to environment. . . . Further progress in ability to relate to others. . . . Still cautious regarding emotional involvements.

CASE 10

Age: 29. Number of sessions: 62. I. Q.: 120.

A. *Psychiatric Evaluation: Persistence* of somnambulistic states in which he shows aggressive behavior. . . . Improvement in psychogenic diarrhea. . . . Diminution in excessive compliance and fear of rejection. . . . More realistic relationship to others.

B. *Psychological Evaluation: Changes between Rorschachs I and II* (test interval 14 months). Thinking more conforming. . . . Less hypercritical though works below capacity. . . . More stable emotionally. . . . Less depressed and withdrawn. . . . Still insecure, self-depreciating, hostile and fearful of close contacts though better able to identify with others. *Changes between Rorschachs II and III* (test interval 13 months). Generally not much change shown. . . . Emergence of tendency to over-intellectualize. . . . Still insecure in personal relationships.

CASE 11

Age: 34. Number of sessions: 49. I. Q.: 101

A. *Psychiatric Evaluation*: Decrease in anxiety and depressive symptoms. . . . Clearing of tinnitus and abdominal pain. . . . Somewhat less shy, able to get and hold onto a better job, still strongly dependent.

B. *Psychological Evaluation*: (test interval 27 months). Some decrease in rigidity and emotional restraint. . . . Continues to be fearful, immature and dependent.

DISCUSSION

That a parallelism exists between clinical improvement and changes in successive Rorschach tests would seem amply demonstrated. This shows itself in all aspects of personality function. However, because the frame of reference of the therapist—who is personally involved in the therapeutic effort—is different from that of the psychologist—who uses an arbitrary though sensitive measuring device—it is to be expected that their separate formulations of the changes occurring in the total personality constellation cannot be equated with each other in any precise way. In addition, certain facets of the total picture are better revealed and estimated from one vantage point than from the other.

In therapy, the only way in which one can observe the patient's functioning directly is to see how he behaves in the therapeutic situation, that is in the transference, admittedly a special sort of relationship. Most of the patient's functioning must be seen through his own eyes, that is at second hand and through an observer who is anything but unprejudiced, i. e., the patient himself. Because of the peculiar nature of the Rorschach examination, it gives an opportunity to observe directly how the subject functions

in an apparently innocuous situation, which in a very real sense simulates a life situation. The patient's approach to the problem, how he perceives test material, to what extent he can utilize his own creative ability meaningfully in it, how conforming he is to group standards and norms, his handling of anxiety-laden and emotionally-charged situations can all be studied, objectively charted, and even quantified, in the administration and scoring of the tests. The basis for an objective comparison of serial tests is therefore created. The study of the Rorschachs in this paper bears this out, namely that one can evaluate change in an objective and qualitatively significant way.

In general, psychosomatic symptoms are not easily inferred from the Rorschach whereas subjective psychological symptoms such as anxiety and depression are usually discerned with ease. On the deepest level, it is questionable how much direct information the Rorschach gives as to psychodynamics, although at times—depending on the richness of the record—a good deal can be inferred from the content. In the therapeutic situation, however, psychodynamics reveal themselves in many ways. For instance, a dream is frequently almost a text in mental mechanisms. In fact, a dream frequently will foreshadow actual overt clinical improvement, which will manifest itself later. Thus, while successive Rorschachs show changes in functioning, they do not usually show why these changes have occurred.

So much for what the Rorschach does not ordinarily reveal. On the positive side, the writers have found it valuable in many ways. It is frequently difficult for the therapist to be objective in his evaluation of his patient's progress, because of the many subjective and unrelated elements involved. Some of the factors which may tend to cloud a true perspective of the patient's progress are the emergence of negative aspects of the transference, changes in the patient's economic status, births, deaths of friends or family members, successes or failures often not related to the patient's own efforts, or rejection or acceptance by loved ones—in short, any extraneous events of either traumatic or supportive nature. At these times, the Rorschach is especially useful because of the important advantage of being objective in its formulation, even though it measures material of a partly subjective nature.

One of the interesting phenomena to be observed in therapy is that patients are often unaware of the changes that occur in them

on a characterological basis. It is a truism that changes in personality under therapy are likely to be noted first in the changed reactions of friends and relatives. This probably occurs for many reasons. In the patient's mind, the emphasis is usually on symptoms, on anxiety, depression and physical complaints, rather than on interpersonal relations.

Also, his changed reactions in various reality situations, occurring spontaneously, will tend to be regarded by him as incapable of having been influenced by the therapist, since they appear to arise, and do in a very real sense arise, from within his own personality. While this is a healthy attitude in therapy, it does make the therapist less dependent on direct observation and reporting by the patient, and more dependent on shrewd guesses as to how much better a patient now handles a problem than he previously could. Also, it should be particularly noted that, while the patient is very eager to be rid of his symptoms; his neurotic way of thinking, feeling and living is equally dear to him. Therefore, he may either minimize characterological changes; or, conversely, he may exaggerate symptomatic improvement to please the therapist and to conceal a lack of underlying change.

At the onset of therapy the Rorschach is of considerable value in confirming the initial diagnostic impression of the therapist and amplifying it, or as sometimes happens, casting doubt upon it. The Rorschach is also of value in determining the suitability of the patient for intensive interpretive therapy. However, it is the writers' belief that the test should not be administered in an indiscriminate or routine fashion. Some patients feel troubled and threatened by the test, sensing that it represents a threat to them in that they will reveal themselves in it; and others become excessively concerned about what the results are. The writers have not hesitated therefore, in deferring the test in cases in which administration would appear to be traumatic. Case 1, the patient who probably showed more improvement than any other in this series, did not have a Rorschach until several months of therapy had elapsed, as it was felt that he would be too threatened by it at the onset of treatment, owing to his extreme anxiety and insecurity.

In the group of the five improved patients given three Rorschachs, it is worthy of note that the psychiatrist felt that the pa-

tients had shown further clinical improvement between the administration of the second and third Rorschachs. This was also borne out by qualitative analysis of the differences between Rorschachs II and III. However, the Munroe inspection technique did not reveal any statistically significant difference. The reason for this would not appear to be too clear. However, it certainly stems in part from the necessarily gross nature of the Munroe inspection technique, which is based on scoring categories rather than on the more subtle differences in responses.

SUMMARY

1. A study was made of a group of 11 psychoneurotic veterans who showed improvement under intensive individual out-patient psychotherapy. Evaluation of improvement was made by the treating psychiatrist and, independently, by the psychologist on the basis of successive Rorschach tests.

2. Utilization of the Munroe inspection technique on the Rorschach protocols revealed significant decreases in the numbers of signs of maladjustment in the improved patients.

3. Utilization of the Munroe inspection technique on consecutive Rorschachs of five patients who had shown no clinical improvement revealed no significant changes in the numbers of signs of maladjustment.

4. A parallelism which reveals itself in many aspects of personality functioning, exists between clinical improvement and changes in successive Rorschach tests.

5. The usefulness of successive Rorschach tests as an aid in the evaluation of improvement in patients receiving intensive psychotherapy is discussed.

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REFERENCES

1. Munroe, Ruth L.: Prediction of the adjustment and academic performance of college students by a modification of the Rorschach method. (Inspection technique.) *Applied Psychology Monograph*. No. 7, p. 104.
8. Cronbach, Lee J.: Statistical methods applied to Rorschach scores: a review. *Psychol. Bull.*, 46:5, 393-430, 1949.

3. Linquist, E. F.: Statistical analysis in educational research. Houghton Mifflin. Boston. 1940.
4. Rorschach, H.: Psychodiagnostics. (Trans. by P. Lemkau and B. Kronenberg.) Grune & Stratton. New York. 1942.
5. Klopfer, B., and Kelley, D.: The Rorschach Technique. World Book Co. New York. 1942.

EDITORIAL COMMENT

TIMEO DANAOS . . .

This QUARTERLY would like to join in the applause for the action of the *American Journal of Psychiatry* in its recent plea for greater clarity and simplicity in scientific (specifically psychiatric) writing.* We have written, more than once, toward the same end ourselves;** and we are glad to see both a growing awareness that there is need of improvement in means and methods of scientific communication, and a hardening resolve by those concerned to do something about it. But we think, at the same time, we have a right to express some concern about the announced aims, and some doubts about the motivations, of some of our fellow-crusaders. What we, as interested parties, issued invitations for was a sober, painstaking and informed review of psychiatric language—not a public auto-da-fe of our scientific vocabulary.

If the *American Journal of Psychiatry* will permit us to join in what we hope is not a private fight (we drew our own sword at Armageddon well over a year ago), we should like to cite it once more to take issue with Morris Fishbein, M. D., who writes to that journal in praise of its editorial attitude.† Fishbein, like the editorial writer of the *Journal's* original remarks on "gobbledygook," cites illustrative cases; unlike the *Journal's* editorial writer, he cites the wrong cases. Neither we nor any other advocates of writing simplicity, of whom we are aware, are suggesting that we go the full length of abandoning our technical vocabularies because persons outside our specialties cannot understand them. Fishbein's communication to the *American Journal of Psychiatry* cites two examples of what he considers "gobbledygook" from the psychoanalytic literature, one from general psychiatric writing, and a list of unusual (to say the least) psychiatric terms.

*Comment; Gobbledygook in psychiatric writing. *Am. J. Psychiat.*, 108:6, 474-475, December 1951.

**Editorial: The editor's schnozzle. *PSYCHIAT. QUART.*, 24:4, 821-830, October 1950. Editorial: The private languages of science. *PSYCHIAT. QUART.*, 25:3, 337-341, April 1951.

†Fishbein, Morris: "Gobbledygook in psychiatric writing." *Am. J. Psychiat.* (correspondence), 108:9, 705. March 1952.

We would not recommend any of the three citations for elementary school English exercises, and would not defend any one as an example of the best possible writing in the best of all possible scientific circles. But all three are perfectly comprehensible, and are comprehensible without undue difficulty, by the specialist readers to whom they are addressed.

Fishbein takes exception to what most of us would consider a rather simple and clear explanation of the development from visual images in child-thinking to the imagos of parents and others which persist through life. "Who," he inquires, "needs that word 'imagos'?" The answer is that a large number of medical specialists do. The imago, those specialists hold, is a particular kind of image, formed under particular circumstances, answering particular psychological needs. It is a factor of the utmost importance in the development and treatment of neuroses. Without a technical term, or a "shorthand" expression for it, the writer mentioning this real—and universal—phenomenon would be under the necessity of describing its functioning, its origins and its characteristics every time he encountered it. Since it is a phenomenon which is no more generally recognizable than the sphericity of the earth or the chemical composition of table salt, there is no vernacular term for it, and a technical term was invented. The common term "image" is not descriptive of, nor specific for, "imago." To use it would be like dropping "dog, cow, pig" and employing the undistinguishing term "mammal," which applies, of course, to all milk-giving animals.

Fishbein does not give specifications in indicting the citation he presents from the general psychiatric literature. He simply "asks," "Isn't that clear?" It concerns a discussion of the hypothetical "impulse neurosis," which, says the quoted writer, "adds nothing new to our study of psychodynamics. It combines the ego-syntonic character of psychopathy with the ritualistic, circumscribed symptomatology of compulsive obsessive [sic] state." With appropriate reservations about the omission of a hyphen and the definite article, any psychiatrist should find it perfectly clear. Possibly "syntonic," as the least common of the technical terms, is the focus of Fishbein's objection. It is a fact that, although the word is attributed to Bleuler, it may be used more commonly in psychology than in psychiatry today; but even the non-psychiatric

reader should find it easier to consult a dictionary than to read the verbose explanation which its omission would require.

"Please translate," is the pathetic appeal appended to the second psychoanalytic citation. It is a citation which includes such words as "libido, libidinal, organ-cathexes, orality, anality and genitality." It is perfectly understandable by anybody with elementary grounding in the common theories of psychodynamics; and we are tempted to observe with some irritation that the modern doctor owes it to his patients, if not to himself, to have at least an elementary grounding in psychodynamics. It was not written, of course, for high-school English classes.

Concerning the list of terms with which Fishbein feels psychiatry might well dispense, he notes three "phobias," a "philia" and the word, "necromimesis," which we believe either he or the glossary he cites misdefines. And here, we agree in principle with him. Some of the "phobias" and the "philiias" have passed into the common tongue: claustrophobia, necrophilia, photophobia. But "cat-phobia" is as exact a term and much more generally intelligible than "ailurophobia," "galeophobia" or "gatophobia"; "dog-phobia" has advantages over "cynophobia" on the same grounds. We think, too, that a reform here would save considerable time, not only among general practitioners but among specialists themselves in reporting psychiatric symptoms. "Mouse-phobia" describes a fairly common symptom accurately—without the necessity of hunting for "musophobia" through phobia lists which may not include it (of two large lists consulted by us at random, one does not). We suppose the philologists and the purists would object; but medicine in general is full of terms to which the philologists and the purists could object; we should be able to stand a few more bastard words in the interests of clarity. And we should like to see a general agreement among psychiatric editors and writers to do something about the "philiias" and the "phobias."

But the whole protest is a piece of scattergun criticism, in which one slug out of four hits a rather large target. We think we could do as well ourselves, with no pretensions whatever to knowing anything about anybody else's specialty. For instance, we might be able to entertain a proposition that we slash in half or translate half of the table of phobias if the obstetricians will slash in half or translate half of their algolagniac table of monstrosities and anomalies. In one of our desk dictionaries, the phobia table

occupies two pages and a half, that of monstrosities and anomalies four and a half.

But we do not think much of this scattergun marksmanship. Maybe the obstetricians and the gynecologists and the geneticists have a good use for and are making good use of their fearful terminology. And maybe there are psychiatrists with whom we are not in contact who have affection for their foreign-language tables of phobias and phobias.

What we are driving at here is the thought that the users of the language are the logical persons to take the first steps toward reforming it. In this *QUARTERLY*'s own discussion of "The Private Languages of Science," the suggestion was advanced that we, the psychiatrists and daily users of psychiatric speech, make the primary endeavor of trying to make our work more intelligible to medical people generally. But there are steps which ought to be corollary to this. We do not think we should be required or expected to attempt to present all psychiatric matters in the terms used in internal medicine. We think medical men generally should have educations that will comprehend the elementary concepts of psychiatry and acquaintance with the more common psychiatric terms. And desirous as we are of seeing improved intradisciplinary and improved interdisciplinary communications, we do not believe that we can or should attempt to make all psychiatric language understandable to non-psychiatrists. We may reasonably expect all physicians, for example, to have a general concept of optics and of the anatomy and physiology of the eye, but we do not expect the ophthalmologist to report more than his general conclusions in terms the profession as a whole can understand. We do not expect either, reaching across the sciences, that the atomic physicist can report in terms for general understanding the experiments and reasoning from which he reaches the famous conclusion that $E=mc^2$.

We think, in short, that more things than charity should begin at home and that all of us, including Dr. Morris Fishbein, would do well to start our reforming with something that we understand. In the particular case of Fishbein, we think, psychiatrists have some reason to question benevolence of intent. During the many years in which Fishbein edited the *Journal of the American Medical Association* and, as most of his critics have always been ready to concede, wrought mightily for the advancement of American

medicine and American practitioners of medicine, he was sometimes regarded by those critics as something of a Czar as well as a benefactor. It was during those years—and following a bitter and ill-founded attack on New York State institutional psychiatry—that this QUARTERLY remarked: “. . . there has been reason to suspect in the past that the great man of Chicago looks upon modern dynamic psychiatry, if not upon the whole specialty, with something of a jaundiced eye—if not indeed with an attitude psychiatrists are accustomed to regard as akin to a paranoid trend.”* In the years since—almost enough years in which to fight a Trojan war—there has been little reason to revise that opinion.

This is not to retreat from our firm position that scientific language is in general need of improvement, but to reiterate our belief that we had better initiate our own reform. We think that, until we have strengthened our vulnerable walls by reforms from within, we should do well to heed Laocoon and fear the Argives (including Fishbein), however great their gifts of well-meant advice. There are many ways of killing a cat; and we have no desire to see psychiatry choke on a surfeit of ill-conceived advice, even if it is presented in the guise of the best butter.

*Editorial: Duce, Duce! PSYCHIAT. QUART., 18:4, 687-690, October 1944.

BOOK REVIEWS

The Psychologist Looks at Sex and Marriage. By ALLAN FROMME.
xv and 248 pages. Cloth. Prentice-Hall. New York. 1950. Price
\$2.95.

The Psychologist Looks at Sex and Marriage is a book of considerable importance to newlyweds who may be uncertain about some adjustments that must be made; to those contemplating marriage who may not be fully aware of the experiences and responsibilities they are about to embark upon; and to those who have "settled down" to married life.

Dr. Fromme's main premise is that a successful marriage is based upon the adjustment of the individuals involved. First, the individual personality is investigated by the author. Ability to think realistically is stressed as one of the most important pre-requisites for a successful marriage. Dr. Fromme feels that one must be able to face his own shortcomings, lest he blame others for them. The mate is the usual victim of this situation, and the home is the battlefield. One's preparation for life itself is a good indication of his preparation for marriage.

The treatment of problems of courtship may be particularly helpful to those who have conflicts regarding pre-marital relations and doubts concerning "true love." The author presents an analysis of aspects which many engaged couples are afraid to face.

Except for its rather weak conclusions concerning divorce, this book is sufficiently basic to improve insight into the problems of domestic relations generally. It is well written, and the topics are arranged to present a unified whole.

Fundamentals of Psychiatry. 5th edition. By EDWARD A. STRECKER,
M. D. 235 pages. Cloth. Lippincott. Philadelphia. 1952. Price
\$4.50.

The fact that this book is in its fifth edition should be sufficient recommendation to anyone. It has grown out of Dr. Strecker's teaching experience and has been a textbook of psychiatry for many medical students.

In addition to the usual items covered in a text, it includes the approved classification of mental diseases and the latest newer classification, considered for approval. The book includes chapters on "Psychiatry and War" and "The Nurse and the Psychiatric Patient." According to the author's preface the chapter, "Psychosomatic Medicine and Psychiatry," has been rewritten and a chapter on psychotherapy has been added. The book also contains a glossary.

Bertrand Russell's Dictionary of Mind, Matter and Morals. Edited, with an introduction, by Lester E. Denonn. 290 pages. Cloth. Philosophical Library. New York. 1952. Price \$5.00.

This dictionary of quotations from the writings of Bertrand Russell is presumably designed as a handy reference work for students of the interrelationships of philosophy, psychology and sociology. It contains nearly 300 pages of Russell's judgments—out of context, of course—on historic figures and theories as well as on men and movements of their times. Its references are complete and dated. This reviewer questions, however, whether such a necessarily incomplete sampling can be of great use except to the specialist in Russell's writings, and the specialist will be able to refer to the sources. To this reviewer, the best part of the book is Lord Russell's own preface. It is a one-page masterpiece in defense of the right of a scientist to change his opinions as new knowledge becomes available. It could bear reading and re-reading by all who are engaged in scientific work.

New Concepts of Hypnosis. By B. C. GINDES. 262 pages. Cloth. Julian Press. New York. 1951. Price \$4.00.

In this text, a doctor reports to the psychological and medical field his general feeling on hypnosis, a feeling which he states is based on serious scientific research and clinical observation of behavior. His book was, apparently, written primarily for the psychiatrist. However, the student of psychology, the general practitioner, and others will find it of interest.

The text presents, in addition to the usual discussion of history and methodology, many examples of hypnosis in practical application. In addition, there is a discussion of some new and original techniques. The book is well written and should be of interest to a rather wide range of professional individuals.

Case-Record from a Sonnetorium. By MERRILL MOORE. Drawings by Edward Gorey. Unpaged. Cloth. Twayne. New York. 1951. Price \$1.50.

Merrill Moore is the author of an enormous amount of verse (it is said to include more than 100,000 sonnets) which has been largely devoted to the characterology of his mental patients. The present collection is devoted to treatment of the sick sonnet, relief from the rules of versification imposed as compulsions by Petrarch or obsessions by Shakespeare. Dr. Merrill's sonnets, while freed from these rules, are verse of the finest workmanship, and are always entertaining. The professional reader will find the cartoon illustrations by Edward St. John Gorey even more fascinating. This reviewer finds one entitled "The Doctor Gives the Sonnet the Rorschach Test" quite unforgettable.

A Wreath and a Curse. By DONALD WETZEL. 210 pages. Cloth. Crown Publishers. New York. 1950. Price \$2.50.

This first novel of an unknown writer has received enthusiastic reviews. It centers around human inefficiency and inability to grasp essentials. A whole family living in a house endangered by the river, ignores the danger and acts in accordance with the individuals' specific hobbies, neuroses, prejudices. The only exceptions are a boy of 10 and his brother, a crippled man. The author is a good depicter of surface reverberations; he is naïve about inner motivation. Such motivation is simply not established by stating that the paterfamilias is interested solely in building a spite fence, charged with electricity, to electrocute the neighbors' chickens disturbing his garden. Nor is it enough to state that a sister is disinterested in anything else but her narcissism, desperately fighting her "ugly" pregnancy. All this may be correct observation; but a writer should be capable of animating people with external and *internal* motives. Even passionate sympathy for the 10-year-old hero does not substitute for a psychological substructure. The book and its reviews are signs of how little intuitive understanding of the unconscious is encountered nowadays in the literary field.

Encyclopedia of Sex Education. By HUGO G. BEIGEL, Ph.D. 441 pages. Cloth. Stephen Daye Press. New York. 1952. Price \$4.95.

This book is described on the dust cover as "An up-to-date guide and reference book for adolescents, marriageables, parents, teachers." An enormous amount of painstaking work must have gone into its preparation. The author, however, has not cited authorities, has not stated from what disciplines or sub-disciplines this term or that term has been derived, and has given a great many definitions which some would consider debatable. With the citing of authorities, this might become a valuable book for reference in any library where consultation on sex information is to be expected. As it is, this reviewer thinks it does not meet the purpose for which it was designed, and wonders just what purpose it can serve in its present form.

Eidolon. By J. DAVID STERN. 246 pages. Cloth. Messner. New York. 1952. Price \$3.00.

This is an attempt, in a New York newspaper setting and a science fiction atmosphere, to present a fantasy on one of the great themes of religion. The subject is one capable of arousing intense philosophical and psychological interest. The author is a "liberal" newspaper publisher of national reputation. In his own field he is regarded as gifted. It is painful, therefore, to record that his novel strikes this reviewer as adolescent in plot and treatment of characters and as missing completely the target of its central theme.

A Dictionary of Psychology. By JAMES DREVER. 316 pages. Paper. Penguin Books, Inc. Harmondsworth, Middlesex. Baltimore. 1952. Price 3s 6d.; 85 cents.

This dictionary is the work of a distinguished British scholar. Professor Drever was the first person to hold the chair of psychology at Edinburgh University and was professor emeritus at the time of his death in 1950. He had just finished revising the book before his last illness; and the publishers note that his son, Dr. James Drever, Jr., successor to his father in the Edinburgh chair of psychology, saw the work through the press. Thus, this volume has an impressive and authoritative source; and it is painful to note that it is not the last word in desirability as a desk book for the American student.

There are, for example, no definitions of some of the most generally used procedures in American clinical work. Finger-painting, the Wechsler-Bellevue test, and the Thematic Apperception Test are among the omissions. The Rorschach definitions are inadequate. The paraphilias are inadequately, quaintly, and sometimes incorrectly, defined; most American psychiatrists, and American psychoanalysts in particular, would find the definitions in their disciplines unsatisfactory.

These criticisms, this reviewer thinks, may be occasioned to some extent by differences in social and professional climates. The American worker can profit by, and make good use of, this book—but not as his primary reference volume. And that is a pity, for it is authoritative, inexpensive and well printed.

Speech Training. By A. MUSGRAVE HORNER. 175 pages. Cloth. Philosophical Library. New York. 1952. Price \$3.75.

The best part of this textbook is its diagrams and exercises, but it adds nothing new to the variety of existing texts on the subject. The material is presented in a dry, factual manner that makes no appeal to the imagination of the reader. It is as if a carpenter laid out his tools and explained the purpose of each one without ever suggesting to the novice what could be made with them.

Selections for oral interpretation are chosen entirely from the classics with no attempt to draw on modern poetry or the rich field of modern prose. They are interspersed with technical comments on such things as the value of the pause . . . a lecture on verse forms . . . and, uninspired references back to technical exercises.

The author evidently believes that techniques are an apt substitute for individual artistry in interpretative reading, and relies on them to win adherents to the cause of better speech. A modern speech teacher's reaction to this book would be similar to her reaction to the methods and practices of the old Latin grammar schools.

Mental Health and Hindu Psychology. By SWAMI AKHILANANDA. xix and 231 pages. Cloth. Harper. New York. 1951. Price \$3.50.

Swami Akhilananda's theme is the achieving of the spiritual understanding of man's oneness with God. Akhilananda says that this understanding should be the higher ideal and the primary objective of life. However, the pleasures of life are not ruled out; they are merely subordinated to the goal.

Akhilananda points out that many persons will not enter into the actual ceremony of marriage because of fearing incompatibility, due to egocentric aggression. He feels that only religion can effectively overcome this complex. Using the race problem as an example, he notes that aggression is used against a minority race, which in time develops a counter-aggression against the majority race. Aggression is shown as destroying human society individually and collectively. The answer the author gives is the development of love through the higher ideal of life.

The author sums up aggression by stating that historical evidence proves that those who take up aggressive and destructive methods are invariably destroyed by those methods. "The only technique for the group," he holds, "is to develop dynamic spiritual individuals who can follow the higher spiritual ideal of forgiveness and love in their interpersonal relationships." Their influence will permeate the behavior of the whole group, which will then express the same idea of the conquest of evil by love.

Akhilananda believes that our competitive, industrial, and technological civilization has brought anxiety, apprehension, frustration, and dissatisfaction to our people. Excerpts from the writings of Sorokin and Mayo are used to support this point. The ordinary man does not realize that his competitive method is robbing himself and his society of what they really want: peace and happiness. The swami feels that if the leading personalities of the world would change their ways and apply the higher ideal of life in their own individual lives, then, by the spirit of co-operation based on a sense of duty, they could save the world from destruction and degradation.

According to Hindu psychologists there are five states of mind: (1) the extreme restless state when the mind has tension and many emotional conflicts and longings; (2) the inert stage in which the mind has lower conscious and unconscious passions, such as anger and lust; (3) the state in which the mind is partly concentrated at times; (4) the concentrated state; (5) the superconscious state. Various emotions, conscious and unconscious, make up these states of mind. Tension and conflict enter into the first three states, because of the wavering and indecisiveness of the mind in relation to different emotions and conflicting urges. Certain types of religion may be at fault in bringing conflict and tension to the individual. Religion may be taught too rigidly to children and in maturity; therefore,

religion may seem unrealistic. Also, many religious teachings are not compatible with the known facts of human psychology.

Akhilananda thinks that mental tension may be created by an erroneous understanding of life. People can become disturbed because of improper functioning of the urge for knowledge, beauty, companionship, love or self-preservation. If a balance is shattered and one of these urges becomes extremely strong, neurotic and psychotic conditions can prevail.

Ambition can be an important element in creating tension, according to the author. Ambition can lead to apprehension when an individual finds that somebody else is either at the spot or is trying to reach the spot that the individual wants or has. Akhilananda concludes that the way to defeat tension is through religion. The moment pleasure is made the primary objective of life, tension is created. The mind is stimulated for more and more desire; and then the spirit of competition, selfishness, and egocentricity brings disturbing mental and physical activities to the individual.

Akhilananda argues that, to remove tension, we must have a sound philosophy of life. We must know what our primary object of life is. This object is the realization that divinity is implicit in man. "Pursue this religious idea for some time intensely, and you will find satisfaction in your mind." In its essence, then, this is the thesis of this strangely-insightful volume.

Classic Crimes. By WILLIAM ROUGHEAD. 449 pages. Cloth. Cassell. London. (British Book Centre, New York City.) 1951. Price \$4.00.

Here are a dozen famous British murder cases reviewed briefly by a renowned editor of matters criminal. They include cases of vast interest to the general student of human behavior as well as to the criminologist.

There is, for example, the Slater case, Scotland's proof that anti-Semitism has brought about more miscarriages of justice than the Dreyfuss trial. There is the strange case of Constance Kent whose mental condition is of great psychiatric interest, and there are the crimes called by the author "The West Port Murders," committed by "resurrection men" who found murder for the anatomists easier than grave-robbing. Aside from their historical interest to the medical profession, the psychopathology of the anatomists who innocently or otherwise suborned these crimes, is worth psychological study today.

William Doughead was a well-known editor and reviewer of criminological material; he edited 10 volumes of the Notable British Trials series. There is some quaintness of language and some of the moral reflections appropriate to such subjects half a century ago in the volume under review here. This reviewer thinks many will agree that they add only to its charm.

Occupational Choice. By ELI GINZBERG, SOL W. GINSBERG, SIDNEY AXELRAD and JOHN L. HERMA. 271 pages. Cloth. Columbia University Press. New York. 1951. Price \$3.75.

Experts from the four major fields of economics, sociology, psychology and psychiatry pooled their knowledge in focusing on the specific problems of occupational choice. Their emphasis and approach was focused on an effort to develop a general theory of occupational choice, and a wealth of case material was collected. Such a general theory was developed, affording, the authors feel, a sound basis for occupational choice-making without the now prevalent waste of individual and community resources.

The data for the study were selected from the age groups of 11 to 24, to see how the process of choice develops from childhood through puberty and adolescence among young adulthood in the upper-income males, lower-income males and upper-income females.

This book should be of particular interest to teachers, vocational guidance counselors, parents, psychologists and educators.

The Golden Bough. By SIR JAMES FRAZER. 864 pages including index. Cloth. Macmillan. New York. 1951. Price \$5.00.

This is a complete re-setting and a new printing of the one-volume edition of Frazer's classic study. No social scientist needs an evaluation of this basic work. It was condensed from 12 volumes by Frazer himself in 1922, and a re-issue was badly needed. Macmillan has produced this one in attractive format. As compared to the reviewer's personal copy which is from the 11th printing (in 1935) of the 1922 edition, the re-issue is a marked improvement typographically and in format. The new type is far more readable and although the volume is expanded more than 100 pages, it is printed on paper which makes it actually thinner than the old issue. It should be noted that this is opaque paper of a good grade. The new binding is handsomely done with a light-colored cloth, making the edition a much livelier contribution to the library shelves than its sedate navy blue predecessor.

Essentials of Behavior. By C. L. HULL. 145 pages. Cloth. Yale University Press. New Haven. 1951. Price \$2.75.

"This volume," the author states, "is designed to present briefly and in an intelligible manner the basic laws of mammalian behavior, and to serve as a useful introduction to the current aspects of behavior theory." The text contains the latest revisions of Professor Hull's basic postulates. He presents experimental data supporting his revisions, and states that he expects further changes to take place as the frontiers of science are advanced.

This text will probably be of interest to students of behavior theory, but, as theory, will be of little practical value to the clinician.

An Educational Psychology of Learning. By J. W. TILTON. vii and 248 pages. Cloth. Macmillan. New York. 1951. Price \$3.50.

Actions, in the field of education, cannot always wait for the formulation of exact theories; one cannot sit back, do nothing, and hope the "true solution" will present itself. One of the first points made in this book is of the existence of wide and divergent speculations regarding the learning process. Facts and theories are collected and work done from the information available. The author plays it pretty much "down the middle" and stays close to generally accepted ideas. In these limited objectives the book is successful, and as a source of material, supplemental to general discussion, the work will find its greatest application. If the book fails to develop a well-co-ordinated, all-inclusive, theory, it is not alone, for the truly remarkable thing to report would be success—if success in this endeavor is indeed possible. The style is a bit heavy, but the subject matter is hardly conducive to rhetoric.

Childhood and After, Essays and Clinical Studies. By SUSAN ISAACS. 238 pages. Cloth. International Universities Press. New York. 1949. Price \$4.50.

The author, who is the former head of the department of child development, University of London Institute of Education, is well known for her writings on the growth and development of children. In this book, she has collected a number of her essays with varied subject content but all touching upon the child's social and emotional needs. Such topics as "The Mental Hygiene of the Pre-School Child," "Privation and Guilt," "Modifications of the Ego Through the Work of Analysis," "Criteria for Interpretation," "A Special Mechanism in a Schizoid Boy," "Temper Tantrums in Early Childhood and Their Relation to Internal Objects," and "An Acute Psychotic Anxiety Occurring in a Boy of Four Years" point to the fact that Mrs. Isaacs is thinking in psychoanalytic terms. The essays are all written in good style and in terms which parents as well as educators can understand and profit from studying.

The Age of Light. By DONALD WETZEL. 315 pages. Cloth. Crown. New York. 1952. Price \$3.50.

This novel describes with compassion, intermingled with surprise, a series of deeply masochistic characters. The author took a good look at the world, did not like it, and prescribed the remedy—love. Unfortunately, neither does he grasp the meaning of psychic masochism, nor the inability of neurotics to love. Hence his remedy is an ineffective pronouncement. One of the characters is a schizophrenic boy; his description is completely out of focus. Otherwise, the book is unpleasantly verbose.

Facts of Life and Love. By EVELYN MILLIS DUVALL. 360 pages. Cloth. Association Press. New York. 1950. Price \$3.00.

This book is an attempt to help 'teen-agers understand themselves and each other and learn how to get along together satisfactorily.

The text is divided into four parts: (1) becoming men and women, (2) deepening friendships; (3) loving and being loved; (4) heading toward marriage. Part 1 deals with such topics as how girls grow up, when boys become men, where babies come from, and sexual troubles and worries. The material is enhanced by 15 full pages of illustrations.

Part 2 covers: getting along in dating, dating know-how, giving and receiving, and parents and dates. Part 3 includes discussions of whom you love and how, how you can tell when you are in love, petting, saying "no," and "love out of bounds." The last section deals with the "one and only," becoming engaged, and getting ready for marriage.

This book is extremely well written and its value is increased by nearly 100 sketches. The topics have been well chosen and represent those which are of primary concern to 'teen-agers.

A Husband in the House. By STUART ENGSTRAND. 279 pages. Cloth. Farrar, Straus and Young. New York. 1952. Price \$3.00.

This author is an old hand at misusing psychiatric topics for poor, though sensational, novels; this QUARTERLY has twice made note of this technique when reviewing *The Sling and the Arrow* and *Beyond the Forest*. The "blurb" of the former book stated quite shamelessly: "Mr. Engstrand found his theme . . . last year when he was re-reading Stekel's writings on abnormal psychology." In the present book, the confession is missing; otherwise, the technique is identical. The topic of the new-old volume deals with a father pathologically attached to his daughter. He systematically attempts to murder his son-in-law, and plans to do likewise with the prospective second son-in-law. Obviously, the author believes he is on firm ground: Who can deny that some psychopathic fathers harbor such attachments? But a murderer must have some kind of psychology of his own, something the author cannot seem to supply. The result does not amount to much—even as a pseudo-sensational "novel."

Live and Let Live. By S. H. KRAINES and E. S. THETFORD. 408 pages. Cloth. Macmillan. New York. 1951. Price \$3.75.

The authors set forth, as their main objective, the attempt to help people gain more secure, successful lives. They deal with emotions and feelings, timidity, irritability, anger, fear, and their effect on health and happiness. Their style is interesting, and the material is presented in a refreshing, and often humorous, manner. The book represents a psychology as well as a philosophy of living which should be of help in dealing with personal problems.

The Why of Man's Experiences. By HADLEY CANTRIL. 198 pages. Cloth. Macmillan. New York. 1951. Price \$3.00.

This book attempts to deal with questions which people usually put to psychologists such as: what accounts for man's anxieties and his expectancies; how and why does he develop attitudes and prejudices; why does the individual build up his own psychological assumptive world, why are some social relationships satisfying; what are the psychological conditions that make for a sense of happiness; what are sound criteria for group and institutional well-being; what are the bases for friendship and loyalty?

"In this book," the author states, "I am trying to outline an approach which may help pose problems from a fresh point of view and thereby increase our understanding. It is an approach based on what seems to me the convergence of evidence from psychology, biology, and investigations of man's social behavior. The approach must, of course, be finally tested against experimental results."

The author has made a valiant attempt to help us understand man, although the extent of his success may be somewhat questionable.

Kunapipi. By R. M. BERNDT. 223 pages including index. Cloth. International Universities Press. New York. 1951. Price \$7.50.

Kunapipi is a study, and detailed description, of an Australian version of the worship of the Great Mother. In it is the age-old enactment of the drama of birth, life and death, with its mysticism and elaborate ritual. The author explains that the book is not intended to be a comparative study of aboriginal religions in Australia and that the works of other field workers are not evaluated herein. Neither is there an attempt at elaborate interpretation in terms of depth psychology. *Kunapipi*, however, presents basic field-work material for those interested in either subject. The society of the Australian blacks is patriarchal. The position of the mother goddess in it is of more than ordinary interest, therefore, to social scientists of our own patriarchal culture.

Pediatric Allergy. By ROBERT CHOBOT, M. D. 284 pages. Cloth. McGraw-Hill. New York, Toronto, London. 1951. Price \$4.50.

This is a book written for the student, pediatrician, and general practitioner, concerning the diagnosis and management of allergic diseases in children. The author provides a brief background for the present concepts of the various forms of allergy and the mechanisms involved in the production of allergic states, as well as the pathology of allergy. He then proceeds to a clinical discussion of the many allergic states seen in children. The role of ACTH and cortisone in the management of allergic problems is included. Illustrations by means of case histories add to the clarity and effectiveness of this book, which the reviewer considers to be a comprehensive, authoritative contribution to this important area of medicine.

The Psychology of Adolescent Development. By R. G. KUHLLEN. 675 pages. Cloth. Harper. New York. 1951. Price \$5.00.

"This volume," states the author, "concerns psychological development during the 'teen years. It is an attempt to examine and describe the essential nature of adolescence in the light of objective evidence provided by modern psychological research."

The book was written primarily for use as a college text in courses on adolescent development. The author has attempted to construct the material so that it would meet the needs of students who have a substantial background as well as of others who may have a relatively limited background in psychology. He covers thoroughly almost all phases of adolescent development, but makes little contribution beyond what is found in numerous other books dealing with the subject.

This text is well written; its major weakness seems to be the lack of deep understanding which is so often seen in the writings of academic psychologists.

Day of Reckoning. By JOHN GARDEN. 222 pages. Cloth. Lippincott. Philadelphia. 1951. Price \$2.75.

Dyke Farne, the hero of Garden's novel, kills his wife on the spur of the moment and thus becomes entangled in a psychological dilemma. Unable to accept the heavy weight of guilt, he eventually admits that he killed her, only to meet disbelief and reluctance to accept the facts on the part of his friends. Questions regarding his sanity impel him toward self-destruction.

"Know then thyself" would appear to be the moral of Garden's work. And yet, although the moral is present, this reviewer (having no unusual powers of identification) did not "live" with the characters and felt that they were mere puppets. One has a tendency to get out of patience with a somewhat weak and unstable hero who "struts and frets his hour upon the stage."

Hope and Help for the Alcoholic. By H. W. LOVELL. 215 pages. Cloth. Doubleday. New York. 1951. Price \$2.75.

Dr. Lovell has written an informative book which can give both encouragement and help to all who are trying to solve the complicated problem of alcoholism. There are excellent chapters dealing with such topics as what is alcohol, the effects of alcohol, what makes an alcoholic, emotional causes of alcoholism, self-help, Alcoholics Anonymous, what the doctor can do, the woman alcoholic, and fact and fiction concerning general thinking related to alcoholism. The author illustrates many points with many case histories; and his text can well be read by all who are concerned with the problem of alcoholism.

Counseling and Discipline. By E. G. WILLIAMSON and J. D. FOLEY.

387 pages. Cloth. McGraw-Hill. New York. 1950. Price \$3.75.

The authors, one a dean of students and professor of psychology, and the other a senior student counselor at the University of Minnesota, define the basic art of disciplinary counseling as consisting "of the skill of the counselor in achieving insight into the fundamental motivations of the student so as to invent a type of disciplinary action which will touch upon and utilize . . ." them. Such a process is intended to minimize "do's and don't's" and stress the acquisition of a sense of responsibility for one's behavior as part of what is to be learned in college.

Causes of misbehavior may originate in psychopathology, in the individual's training, or in social mores. Also, certain high schools use disciplinary methods that often result in the student's acquisition of anti-authority attitudes. Or the changing content of behavior prohibitions may be still another basis for misconduct.

Complaints come under the general headings of financial irregularities, disorderly conduct, sex misconduct, theft, misuse of privileges and "miscellaneous," the latter including cheating in examinations. Of these theft is the most frequent major crime. In the present volume, the personality defects underlying such manifestations are analyzed and documented by evidence from psychiatrists and specialists in related fields.

Methods noted for dealing with these problems include strict and impersonal enforcement of rules and regulations, indulgent laxity, preventive group work and individual counseling. The authors favor the use of a professionally-trained counselor, supplemented by a faculty committee to serve as a review and appeal board for more serious cases. The successes and failures of this method may be judged by the numerous cases contained in the appendix of the book, all of which were taken from University of Minnesota files.

The Philosophy of Civilization. By ALBERT SCHWEITZER. xviii and

345 pages. Cloth. Macmillan. New York. 1949. Price \$5.00.

Civilization, in the view here presented by Albert Schweitzer, depends for its continuance and progress, and indeed for its existence, on the maintenance of an optimistic-ethical world-view. The spiritual element of civilization, in the ethical rather than the religious sense, Schweitzer believes to have been largely lost to us. Schweitzer's ethics would include mysticism, without the making of mysticism a withdrawal from civilization. The other main ingredient of Schweitzer's civilization would be optimism—a definite denial of fatalism and of any creed that accentuated a feeling of resignation.

Understanding Fear in Ourselves and Others. By BONARO W. OVERSTREET. 235 pages. Cloth. Harper. New York. 1951. Price \$3.00.

Perhaps one can say that this author is following through some additional thoughts pertaining to a "more practical" type of psychiatric thinking first made popular by the late Harry Stack Sullivan. Mrs. Overstreet, well-known writer, lecturer and educator, uses non-technical terms to explain her ideas.

What the author believes and what she has to say in her book can best be summarized by quoting:

"The person who is possessed by fear expects to be hurt. Expecting to be hurt, he works out a way of life that is primarily a way of playing safe; and all his attitudes and actions become progressively expressive that way. He retreats, for example, into undemanding meekness and conformity—as though to make himself too insignificant for fate to bother with. Or he stands wistfully on the sidelines of life, waiting for others to notice him—and often blaming them as selfish if they do not make the approach that he himself feels unable to hazard. Or he takes the initiative in hurting: turns his hostility outward as a will to belittle, to dominate, to destroy; or turns it inward and 'punishes' himself by becoming ill, accident-prone, or subject to compulsive blunders that make him fail and fail again. . . .

"A further agreement, implicit in every type of modern psychotherapy, is that in the last analysis the individual cures himself by understanding himself and setting himself free. The therapist creates and sustains an atmosphere suitable for the patient's self-discovery; but he does not, and cannot, put into the patient the strength he needs for meeting his problems and dealing with them. That strength is part of the patient's own human resource. It comes out as he gradually understands why he has, in the past, behaved in self-defeating and conflictual ways. If, at the end, the patient goes forth healed, he goes forth with the inherent strength and dignity of the self-healed."

The Lighted Cities. By ERNEST FROST. 253 pages. Cloth. Harcourt, Brace. New York. 1952. Price \$3.00.

It is probable that the exaggerated language of the dust jacket, "Ernest Frost writes with great subtlety and spiritual penetration; his deft portrayal of the 'lighted cities of the brain' entitles him to a prominent place in the rising generation of British writers," will prove to be no more than a publisher's dream. Two facets of homosexuality (one conscious, the other unconscious) are depicted. Unfortunately, one comes to the conclusion that the author is far from understanding the inner mechanisms involved. It is true that his *surface* descriptions are slightly above the typical, miscarried, attempts to approach the problem.

The Gates of Hell. By CALDER WILLINGHAM. 190 pages. Cloth. Vanguard. New York. 1951. Price \$2.50.

Reach to the Stars. By CALDER WILLINGHAM. 223 pages. Cloth. Vanguard. New York. 1951. Price \$3.00.

The Gates of Hell is a misnomer for *The Gates of Immaturity*. Twenty-five short stories are collected, written with the naïve cynicism of an adolescent. The mood, psychic nihilism; the posture, tongue-in-cheek; the purpose, clowning. The usual banter is amusing for five minutes, and boringly repetitious for the two to three hours required for reading all the stories.

Reach to the Stars gives the impression that a first draft has been used, that of a previous book by Willingham: *Geraldine Bradshaw*. The identical setting, the teasing-cynical tone, etc., are once more encountered—hastily changed into a “continuation.” What is missing is the heroine, Geraldine. Whereas, previously, an elaborate plot was worked out, and the relation of an unconsciously homosexual man was portrayed in relation to a teasing woman, only sketches are discernible in this book. Economy is laudable; why should unused drafts not be utilized? Of course, one cannot exactly expect this technique to add up to a readable novel, even if the homosexual elements in the pseudo-dramatic personae are more pronounced. Finally, the style of the book fits well into the general picture. To exemplify:

“Dear St. John: Thanks for yours of the 26th, you syphilitic whorehound, I received it and read it with sociological interest, and with ‘literary’ interest as well. Of course, this letter, like anything produced by that fetid brain of yours, is a concoction blended from various revolting swills ever handy to your depraved reach, but, be that as it may . . . [p. 119] This job bores me . . . Did you ever hear Alexander Pike was gay? He sure is. A real gay boy despite that baritone voice and jaw of sheer flint, and what a dumb sap. I thought fairies were supposed to be clever. . . . [p. 121].”

The author lets one of his characters say: “The world is knee-deep in horseshite [p. 149].” Generally, these deep revelations are expressed in literature in a more readable and amusing fashion.

Psychoanalysis and Group Behavior. By SAUL SCHEIDLINGER. 225 pages. Cloth. Norton. New York. 1952. Price \$3.75.

This book impresses one as resembling the outlines of a Ph.D. dissertation, rather than an original contribution. The description of Freudian theory is inadequate; it suffices to mention that such “negligible” topics as pre-Oedipality, orality, masochism, etc., are missing in the index. The description of the role of the super-ego is on the same level. Why such books are published, is unclarified. Repetition of the already known (and inadequately simplified) is a poor recommendation.

My Son's Story. By JOHN P. FRANK. 209 pages. Cloth. Knopf. New York. 1952. Price \$3.00.

Is the home or an institution the best place for a retarded child? How can the parents handle such a situation most wisely for the mental health of the infant, themselves, and other members of the family? Does self-sacrifice or self-discipline provide the answer?

To reply to these questions and "to help the next fellow along the same path," John P. Frank, a teacher of law at Yale has disclosed the struggle that took place when he and his wife were forced to adjust to the fact that their son would never be normal. They passed through successive stages of suffering, hope and despair and emerged, determined to go on with life. With the help of sympathetic physicians, friends and a Roman Catholic institution that is staffed to give such children decent, healthful care, the Franks have carried on. Their story is a most moving human document. The advice of one doctor to the harassed father is worth noting. "Your own peace of mind will be greater if your child's care is entrusted to someone who sincerely believes that the spirit of God is in that child and regards her task not as a job to be got over with but as a duty done in a great cause."

The book is fittingly dedicated to the Felician Sisters of St. Rita's Home, Buffalo, N. Y. It belongs to everybody.

Brain-Washing in Red China. The Calculated Destruction of Men's Minds. By EDWARD HUNTER. viii and 311 pages. Cloth. Vanguard. New York. 1951. Price \$3.50.

Edward Hunter's tale of *Brain-Washing in Red China* reveals the methods of psychological warfare being waged by China against the free world. What is even more shocking, is the revelation that China is thorough in its methods, and not only appeals to the masses, but also to men and women of so-called "higher intelligence."

The author shows how educational techniques, diaries, and even cartoons play an important part in this methodology of psychological warfare. Plays and movies also are employed, with every theme symbolic of the struggle of the "people" against "capitalism," and every theme directed against the United States.

The psychological warfare described here makes one realize more poignantly how very precise the Reds are in their methods. The job of "brain-washing" in Red China is very thorough, and the free world must be very careful to be alert to these tactics.

The Anatomy of Happiness. By MARTIN GUMPERT, M. D. 310 pages. Cloth. McGraw-Hill. New York. 1951. Price \$3.50.

Dr. Gumpert, a research fellow in geriatrics at New York University and author of *You Are Younger Than You Think*, explores the many reasons that so many persons lead unhappy lives. "Happiness" is an intriguing yet an intangible word, which has caused many writers to explain their theories and philosophies.

Dr. Gumpert's book is directed, mainly, to the older person; but his ideas pertaining to the attainment of happiness apply to every person. The arrangement of the book suggests a collection of brief essays on types of emotional expression, and on the physical diseases which pursue the older person. He describes emotional development from childhood through old age. He writes about hope and other "Tools of Happiness," but he says:

"There is no easy prescription to happiness. As the health of the individual can be safeguarded only if the general principles of wisdom combine with the specific wisdom of each individual organism, so must every one of us solve the problem of his own happiness in a unique manner for himself. It is the privilege of human beings to weave the fabrics of their own fate. However, all of us work with the same tools. We have to know these tools of happiness and have to learn how to use them."

Finally, realizing that religion becomes most important to the older person, Dr. Gumpert gives his views here also.

Psychology in the Service of the School. By M. F. CLEUGH. vii and 183 pages. Cloth. Philosophical Library. New York. 1951. Price \$3.75.

Throughout the interesting and worthwhile book entitled *Psychology in the Service of the School*, the author, M. F. Cleugh, dwells upon two major themes: (1) There is a distinct difference between the "unusual" child and the "maladjusted" child which must very definitely be understood by every teacher in any school system; and (2) at the first stage of difficulty in school, the teacher should *not* run directly to the psychologist with child in hand, but try to work out the problem with the child, parents, and other teachers. This is essentially the theme and thesis of this volume.

"Only on *discriminating* judgments can the wise handling of individual children, which we all desire, be established." This means, in the author's thinking, that a middle-of-the-road attitude must be adopted toward the devices of psychology in the school. It is just as unwise to let a maladjusted child slip through the fingers of the teachers and principal as it is to find "hidden meanings" in every action of the child. The author rightly applies this middle-of-the-road policy to everything which concerns a normal child.

The topics of which the author treats are in this order: (1) Judgments and Misjudgments; (2) The Meaning of Maladjustment; (3) Fight and Flight; (4) The Handling of Aggressive Reactions; (5) The Handling of Regressive Reactions; (6) A Mixed Bag of Examples; (7) A Practical Guide to Action; (8) Child Guidance.

The policy of "everything in moderation" must be adopted, according to Cleugh; he stresses that when the child is given treatment, the co-operation of the parents and the school is absolutely necessary for good prognosis. In summation, the author feels that psychology in the service of the school means better trained staffs and more understanding upon the part of faculty members themselves, rather than the setting up of a complicated center for so-called "problem" children. Only the severely-maladjusted child should receive treatment from trained psychologists; otherwise their offices would be overflowing with simply "unusual" children.

Training for Parenthood. By GELOLO McHUGH. 234 pages. Cloth. Family Life Publications, Inc. Durham, N. C. 1950. Price \$3.00.

In the acknowledgments in *Training for Parenthood*, Dr. McHugh expresses his "thanks to the parents and potential parents" who attended his classes and stimulated him to answer the common questions of parenthood. It is evident that he has made a sincere effort to answer a few; wisely, he realizes that to answer all would be impossible, and he is careful to refrain from generalities.

Dr. McHugh briefly enlightens prospective parents as to how to formulate the most satisfactory psychological attitude toward parenthood, explaining, too, why it is significant to form the correct attitude.

Dr. McHugh lays great stress upon the fact that generalizations on the basis of "old wives tales" of child care are sometimes dangerous and often fallacious. He tries to instill, instead, confidence in the physician or obstetrician. He seeks to impress potential parents with the importance of frequent medical attention, in contrast to superstition.

Dr. McHugh stresses the fact that realizing the importance of training in advance makes for happy, successful parents. As he says, "This preparation should include knowledge of both the physical and psychological characteristics of babies and young children as well as information about physical and psychological needs."

The treatment of the material in this book is simple and very logical. The author starts with creation of the proper attitudes toward parenthood, then deals with the problems of parenthood itself, and finally discusses preparation of a proper attitude in the child itself when expecting the next sibling.

Truth Will Out. By CHARLOTTE HALDANE. 339 pages. Cloth. Vanguard Press. New York. 1950. Price \$3.50.

Truth Will Out, by Charlotte Haldane, is predominantly concerned with the question of loyalty. It takes on double significance because Charlotte Haldane's ex-husband, J. B. S. Haldane, is still one of England's leading Communists, while highly regarded in the scientific world. Its value and timeliness lie in its revealing account of how a well-educated and highly-intelligent woman adopted the Communist cause and how she later saw Communism as it is, and broke finally with the party and her husband.

Mrs. Haldane, an idealistic person, was sensitive to racism. The threat of Hitlerism and its perils affected her greatly, and she was convinced by Russian propaganda which preached no racism in Russia, no anti-Semitism, and no anti-Negro bias. The author never reveals the exact time of her joining the party. It appears to have been a gradual process involving at the start peripheral and "fellow-traveler" jobs. Her first real work for the party was the smuggling of Englishmen in Paris to Spain to fight with the International Brigade against Franco.

Mrs. Haldane's account of her visit to China and her comparison of China and Russia should be of interest to all Americans today for the first-hand information it presents. Practically every page of this book contains the name of some world-famous person whom Mrs. Haldane encountered, as she worked for Communism in England, France, China, Spain, and Russia.

The author tells her story calmly and unemotionally. Just as she entered the party without melodrama, and just as she deals with her actions for the party without theatrics, so she left the party. Her reasons culminated during her second visit to Russia. All her idealistic views about Communism are now shattered. She feels that Communism and Hitlerism are not so very different. Her account of her break with her husband after her dis-affiliation with the party is revealing. Mrs. Haldane feels she has recovered her spiritual freedom and personal honor, and her account ends on a hopeful note.

Journey Through Utopia. By MARIE LOUISE BERNERI. xi and 339 pages. Cloth. Beacon. Boston. 1951. Price \$3.75.

In *Journey Through Utopia*, Marie Berneri presents a general survey of utopian thought from ancient Greece to the present day, covering those utopias which either have enjoyed great popularity or have had much influence on modern utopian thought. A utopia has been defined as "an ideal commonwealth whose inhabitants exist under perfect conditions." The works presented come as near as possible within the scope of this definition.

But a utopia has also been defined as "an imaginary conception of an ideal government." Usually the utopian story is based on an ideal commonwealth on some imaginary island or continent in the past or in the future. Many descriptions of ideal imaginary commonwealths are to be found in the stories of imaginary travels popular in the seventeenth and eighteenth centuries. Sometimes the description of the ideal country is very vague, while at other times, as in Gabriel de Foigny's *Adventures of James Sadeur*, it occupies a more important place than the relation of adventure and travels. Only the latter type of utopia has been included in this book. There are also present-day utopias—and the criticism directed toward them by writers with an anti-utopian trend.

For the reader's benefit the book has been divided into six chapters, each one having a collection of works from the same historical period.

The last few chapters are concerned with utopias of the nineteenth century through the present day. The difference between those written after the nineteenth century is that they break with tradition by refusing to describe a perfect society, the main idea being "a state of affairs at once possible and more desirable than the world in which we live." *Journey Through Utopia* is a book with both historical and psychological significance, relating the thoughts of men to the possibilities inherent in their living.

Conscience and Reason. By GRACE STUART. 220 pages. Cloth. Macmillan. New York. 1951. Price \$3.50.

One may be misled by the title of this book, as it is far from being a limited study of conscience and reason in man. Tracing, from a Freudian point of view, the development of man's conscience, the author proceeds to develop ideas on the causes of many of the conflicts of modern society—both within the individual and in relationships between individuals. Conscience and guilt feelings are held to be, not inborn, but the products of environmental conditions. The conscience is not conceived as an agent toward attaining "goodness" but an agent toward gaining approval. The Oedipus situation is described as normal at the time of its development and as not persisting if extraneous influences do not cause it to do so. The author believes strongly in emphasis upon the goodness of life and those things that comprise it during the upbringing of a child, as a means of combating the development of guilt feelings at a later date.

ERRATUM

Learning Theory and Personality Dynamics. Selected Papers. By O. HOBART MOWRER, Ph.D. 726 pages. Cloth. University of Illinois Press. Urbana. (instead of Roland Press, New York, as in published review, page 294, Part 2, 1951 Supplement). 1950. Price \$7.50.

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OSCAR PELZMAN, M. D. Dr. Pelzman, born in Austria in 1911, was educated in Vienna and was graduated in medicine from the University of Vienna in 1936. His special interests were pathology and histology. Compelled to leave Vienna in 1938, he went to Italy for a time and, in 1941, came to the United States. He became instructor and research assistant in pathology at Yale University Medical School in 1943, and, in 1945, joined the psychosomatic research group headed by Dr. Flanders Dunbar, Presbyterian Hospital, New York City. He joined the staff of Central Islip (N. Y.) State Hospital in 1946. He is a member of the American Psychiatric Association, of the American Psycho-somatic Society, and a diplomate of the American Board of Psychiatry and Neurology. He is author of several papers on psychiatric problems.

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BENJAMIN MALZBERG, Ph.D. Dr. Malzberg is director of the New York State Department of Mental Hygiene's bureau of statistics. A graduate of the College of the City of New York and of the New York School of Social Work, he has A. M. and Ph.D. degrees from Columbia University; and he studied on a sociology fellowship at the University of Paris and University College, London. Dr. Malzberg was statistician of the New York State Board of Charities before coming to the New York State Department of Mental Hygiene, where he became senior statistician and assistant director of the statistical bureau in 1928. He has been head of the bureau since 1944.

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Miss Kalkman is a graduate of Brown University and the United States Army School of Nursing. Her psychiatric nursing experience has included supervising and teaching positions at the Psychiatric Clinic, Yale University; Worcester (Mass.) State Hospital; the Neuro-Psychiatric Institute, University of Michigan; the Illinois Neuropsychiatric Institute, University of Illinois; and Napa State Hospital, California. Since July 1950, she has been on the faculty of the University of California School of Nursing.

She has served as consultant in psychiatric nursing to the United States Public Health Service and is on the committee on psychiatric nursing of the National League of Nursing Education. She is the author of the textbook *Introduction to Psychiatric Nursing* and has published several articles on psychiatric and neurological nursing problems.

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MILDRED CERES. Miss Mildred Ceres is a native of Brooklyn and spent her early life there. She received a Bachelor of Arts degree from New Jersey College for Women at New Brunswick in 1943, majoring in psychology, and received her master's degree in psychology from the State University of Iowa in 1946. Most of her training in clinical psychology has been in New York State institutions: Letchworth Village, the State Training School for Boys and Rockland State Hospital. She was associated with the Children's Unit at Rockland from 1945 to 1948. Between 1948 and 1950 she was a clinical psychologist at the Brooklyn Regional Office of the Veterans Administration and subsequently at the Erie Guidance Center, Erie, Pa. At the present time she is with the Westchester County Children's Association, White Plains, N. Y. She is an associate member of the Society of Sigma Xi and of the American Psychological Association.

NEWS AND COMMENT

"GUIDEPOSTERS" SERIES ISSUED BY N. Y. DEPARTMENT

A series of posters, printed in the colors of the rainbow and dealing with mental hygiene in significant periods and occurrences of life, has been published by the New York State Department of Mental Hygiene. Available for Mental Health Week early last May, the posters are on 14"x22" cardboard, and were printed for distribution to recognized agencies and organizations in the mental health field. New York State distribution of single sets to such groups is free, and it is expected that out-of-state requests will be met on a cost basis.

HENRY C. LINK, Ph.D., PSYCHOLOGIST, DIES AT 62

Henry C. Link, Ph.D., psychologist, writer and industrial counselor, died in Scarsdale, N. Y., on January 9, 1952 at the age of 62. Dr. Link was an officer and director of the Psychological Corporation, of New York City, and was the author of a number of widely sold popular volumes, as well as of numerous popular and scientific articles. His last published book, *The Way to Security*, appeared in October 1951.

FACTS AND FIGURES BOOKLET ISSUED

The National Association for Mental Health, Inc., has issued, as of April 1952, a pamphlet aimed to aid persons "who have occasion to interpret to the public the facts about mental health and mental illness in the U. S." The pamphlet, entitled "Facts and Figures," gives brief notes on three groupings: the mentally ill, those with other personality disturbances, and the mentally deficient. The pamphlet gives facts and figures on such subjects as the numbers of mentally ill, the ages at which mental illnesses occur, the most common mental illnesses, facilities for treatment, costs, and other matters. It is designed, the association notes, for use by mental health associations, other organizations, writers, editors, commentators and speakers, and other interested individuals. The address of the association is 1790 Broadway, New York 19, N. Y.

GENERAL SEMANTICS WORKSHOP ANNOUNCED

The 9th Summer Seminar-Workshop of the Institute of General Semantics will be conducted in 1952 at Bard College at Annandale-on-Hudson from August 17 to September 1. The enrollment is limited to 30 persons.

INTERAMERICAN SOCIETY OF PSYCHOLOGY ANNOUNCES AIMS

The Interamerican Society of Psychology (*Sociedad Interamericana de Psicología*), formed during the International Congress of Mental Health in Mexico City in December 1951, announces that its first annual meeting will take place in Caracas, Venezuela in December 1952. The society, to be known by the abbreviated title of *s I p*, plans to organize interchanges of students and teachers, to found a bi-lingual journal, establish a film library, and undertake an active program for inter-American co-operation. American psychologists may make applications for membership, each accompanied by a *curriculum vitae*, in triplicate, to Dr. Werner Wolff of Bard College, Annandale-on-Hudson, who is vice president of the society.

The society explains its purposes: "One special aim is the clarifying and fortifying of the position of psychology as a science by means of the establishment of six points concerning the following problems: (1) Methods, goals and limits of psychology. (2) Formulation of a unified study plan concerning the careers and specialties of psychologists. (3) Professional and legal requirements of a practicing psychologist. (4) Elaboration of a basic topical bibliography. (5) The defense of cultural values and the psychologist's contribution in a time of emergency. (6) Inquiries into and evaluation of the state of psychology in the various American countries."

CLARK L. HULL, Ph.D., YALE PSYCHOLOGIST, DIES AT 67

Dr. Clark L. Hull, Sterling Professor of Psychology at Yale University since 1947, died in New Haven on May 5, 1952 at the age of 67. He had been on the Yale faculty since 1929. Dr. Hull was known for his work on learning and adaptive behavior and for study of the mathematical relationships in behavior patterns. He was the author of *Principles of Behavior*, published in 1945, for which he received the annual Howard Crosby Warren Medal of the Society for Experimental Psychology. His book was revised and re-issued last year under the title of *Essentials of Behavior*. A book on individual behavior, completed by him last year, is scheduled for publication in 1953.



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